FFM
Application Process

Application Process

Online

Quick

Dynamic application that gathers all necessary information

Complete process at one time

Must create an online account

Must pass ID Proofing before moving forward

Paper

Can complete several in a single event

Can send copies of ID information with application

Delays

Must wait for FFM to enter

Questions may not be answered completely

Will involve follow up

Call Center

Quick

All info is entered

Complete process at one time

Cannot see the screen when they are reviewing available plans

Wait times during OEP

FFM Application Process

Apply online at HealthCare.gov

- **Create a HealthCare.gov account**
  User name and password
- **ID Proofing**
  Verifies Identity
- **Complete Application electronically**
- **Receive Eligibility Determination**
  Alerted if there is a Data Matching Issue (DMI)
- **Enroll in a plan**
- **90-95 Days to resolve DMI by uploading or mailing documents**

Application Process

Apply by calling the Health Insurance Marketplace

Call Center number 800-318-2596 (24/7)

- Assisters can call with the individual to assist in application process. Verbal Authorization will be required.
- Interpretation Services Available

- **Do not need to create a healthcare.gov account to apply and enroll**

Application Process

Apply with paper application

- **Enter all information into the paper application**
  Include copies of any documents
- **Mail application**
- **Healthcare.gov receives and enters information**
  May contact consumer if more information is needed
- **Consumer will be mailed an eligibility determination within 2 weeks**
  Eligibility determination may include any Data Matching Issues (DMI) that need resolved.
- **Create an online account or use the Marketplace Call Center to enroll.**

Application Process

Application ID

- Each Marketplace application has a unique identification number, or Application ID. Notices and correspondence from Health Insurance Marketplace will contain Application ID.
- Consumers will need their Application ID to continue with an existing online application, compare plans, and complete enrollment.
- Consumers can provide their Application ID to the Marketplace Call Center representative when calling for application look up.
- When continuing an application, comparing plans, and enrolling online, consumers will be asked to enter their Application ID after they have logged into their account and select "Find my existing application."

Application Process

Health Insurance Marketplace

Department of Health and Human Services
465 Industrial Boulevard
London, Kentucky 40750-0001

May Leon
[insert address]

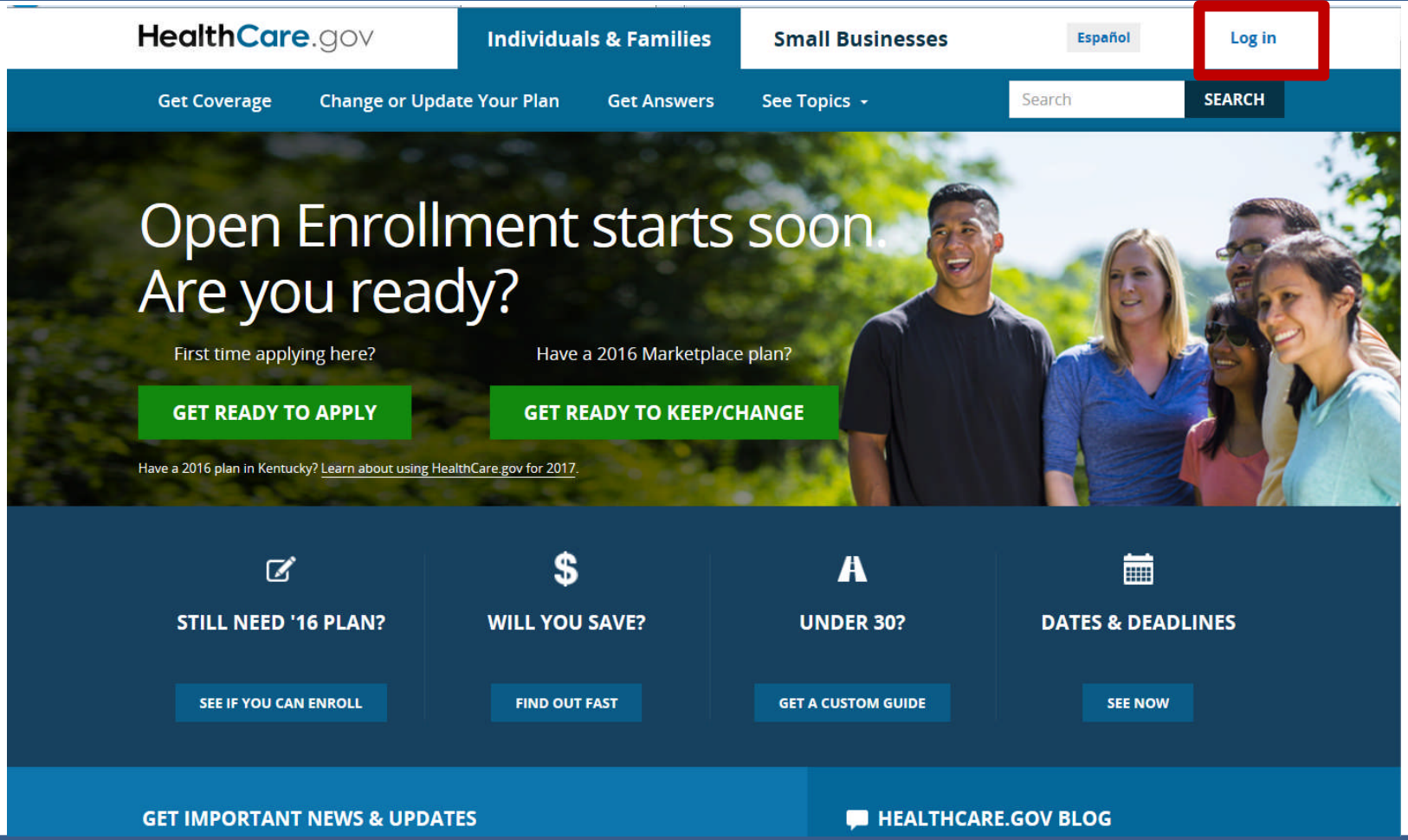
[date]

Application Date: [date]
Application ID: 129990294

Important: Your **Eligibility Results** for Health Insurance Marketplace coverage

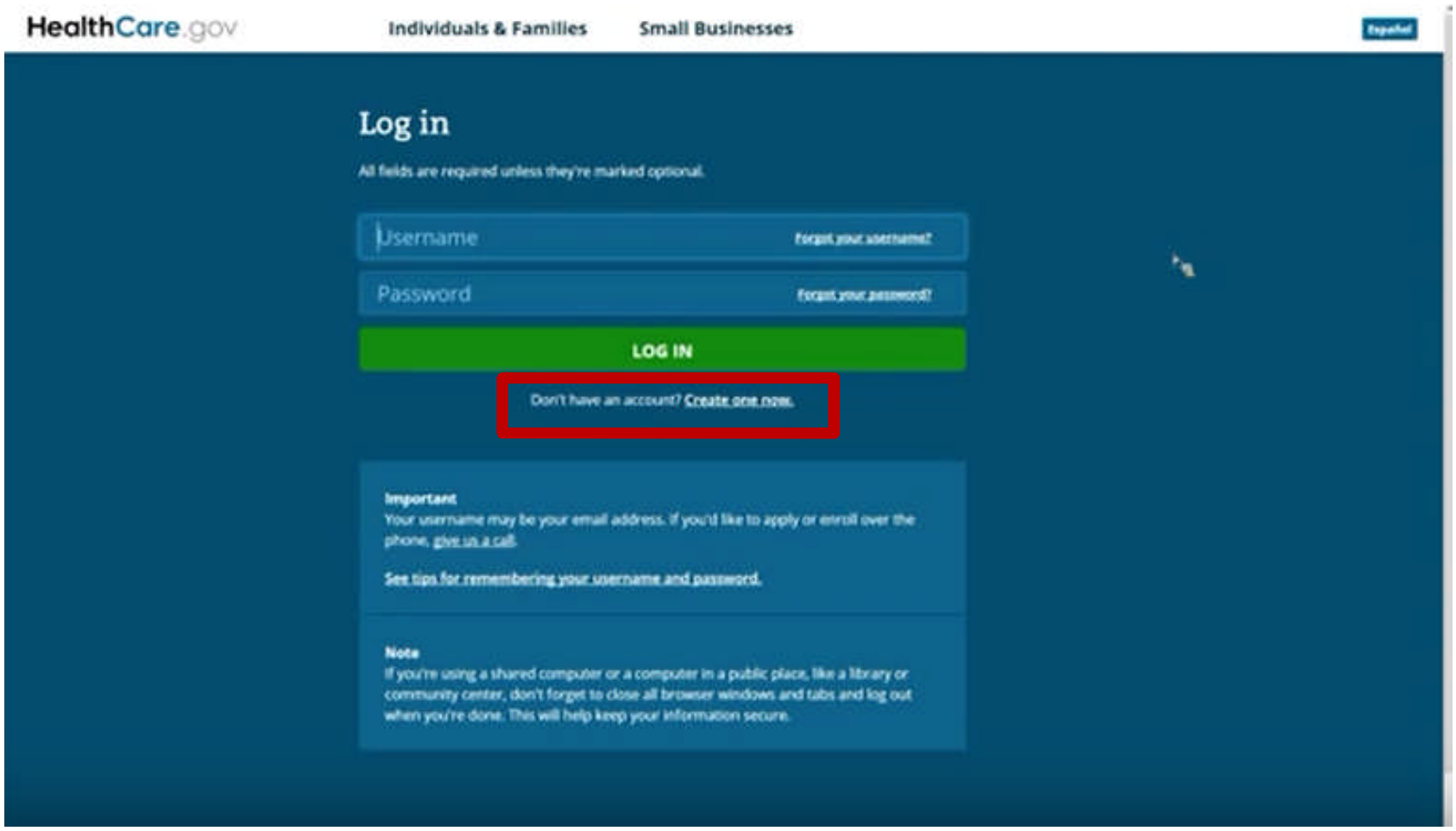
Online Application

Application Process

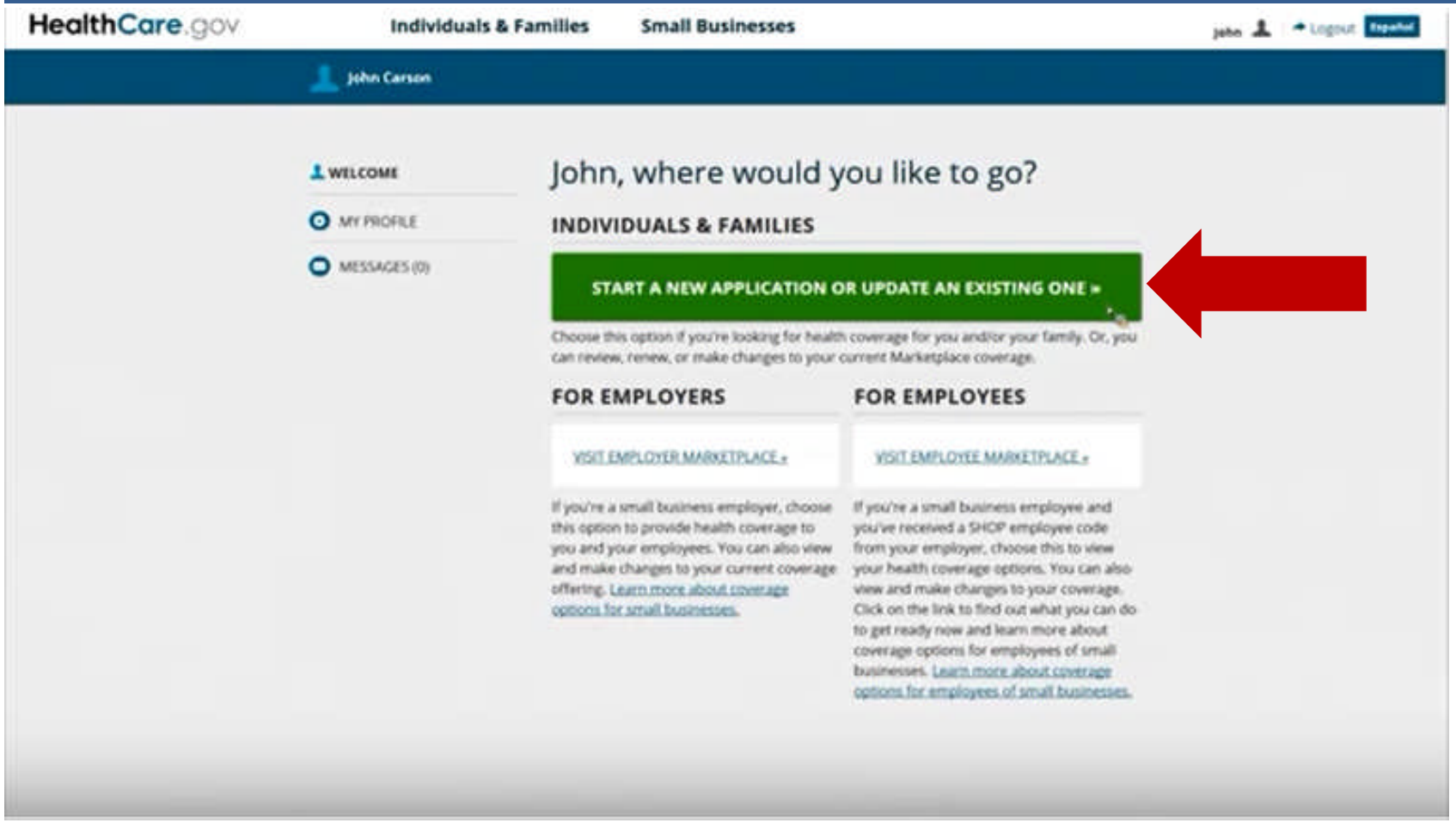


KHBE
Kentucky Health Benefit Exchange

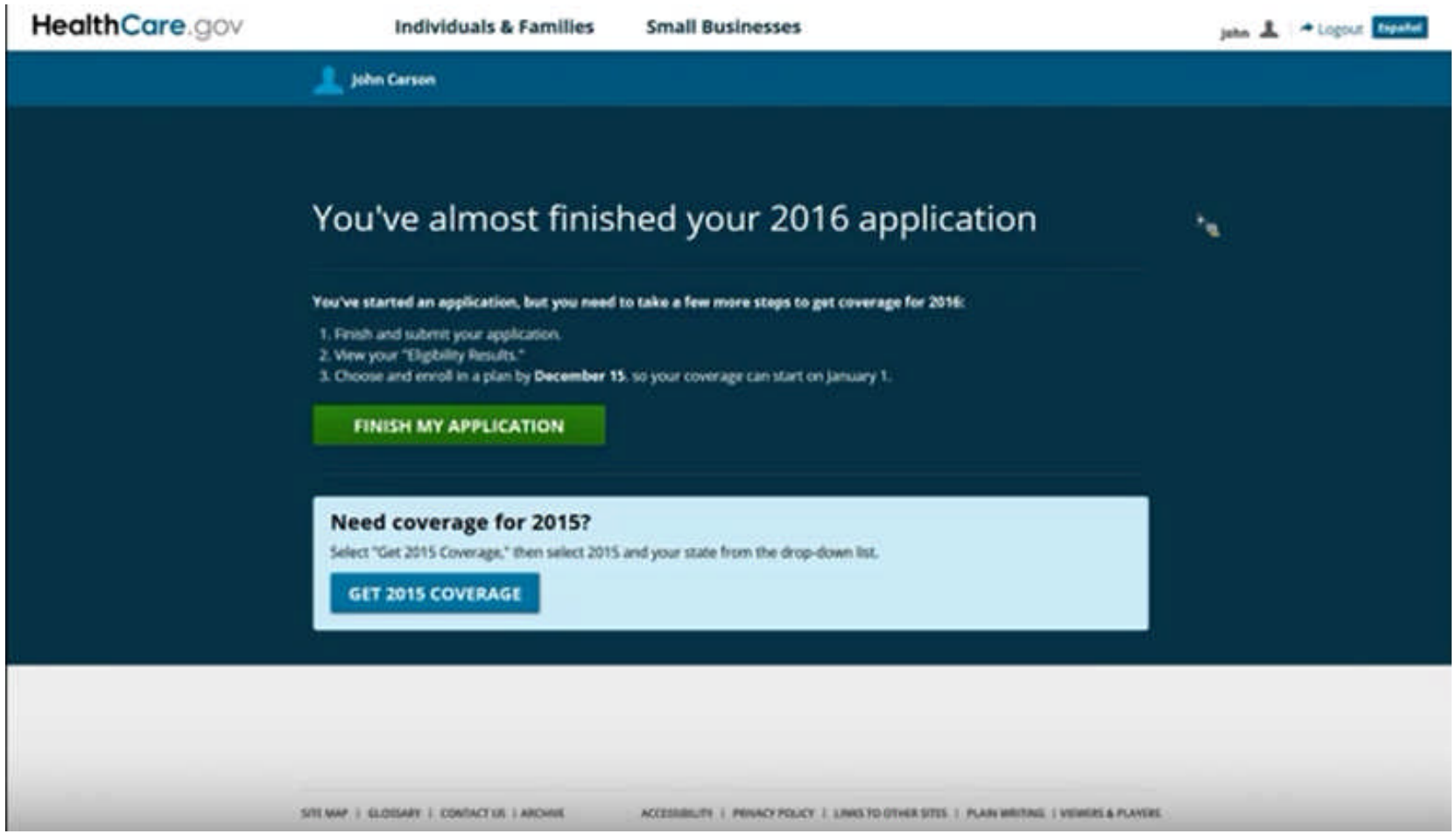
Application Process



Application Process



Application Process



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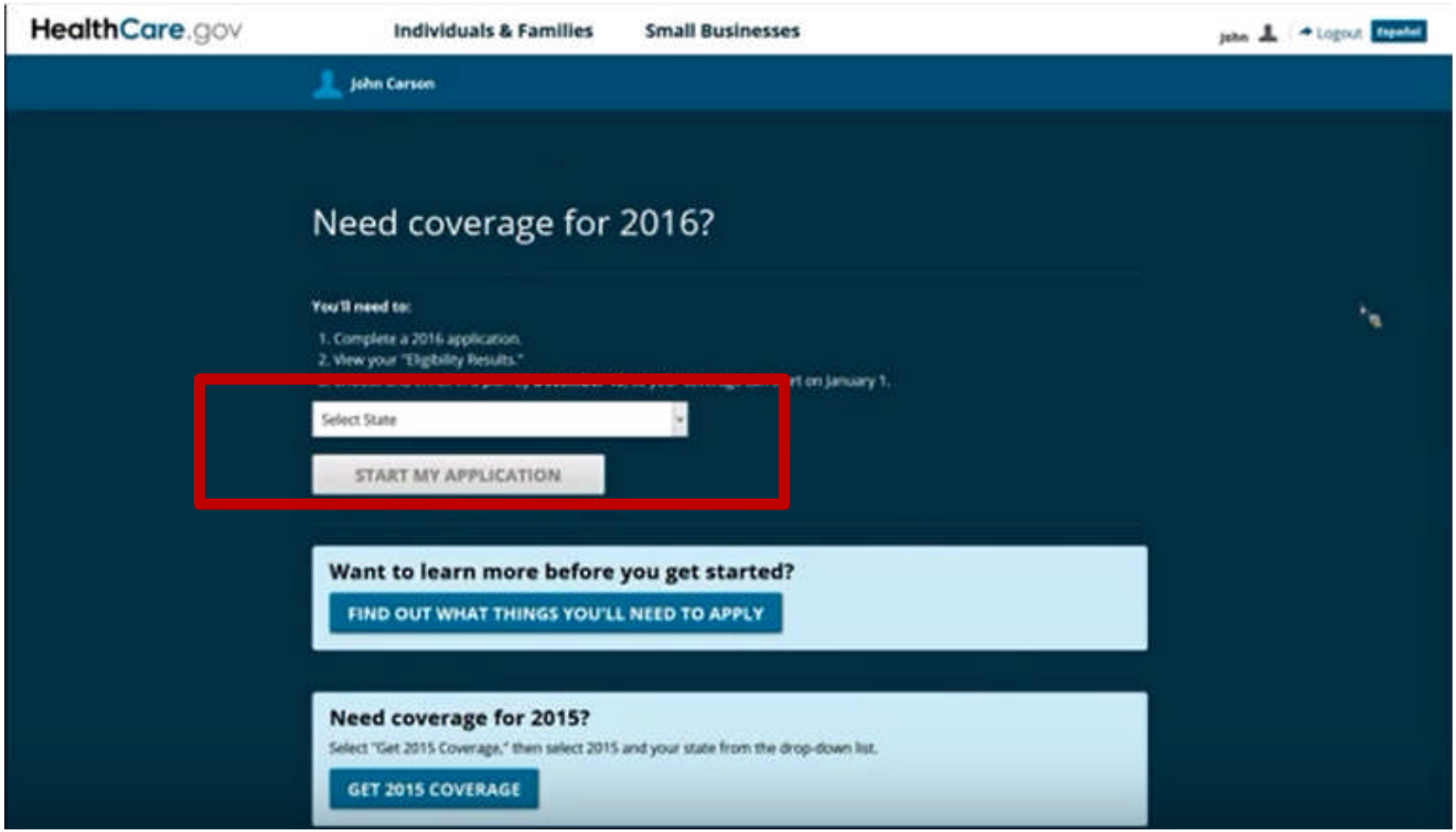
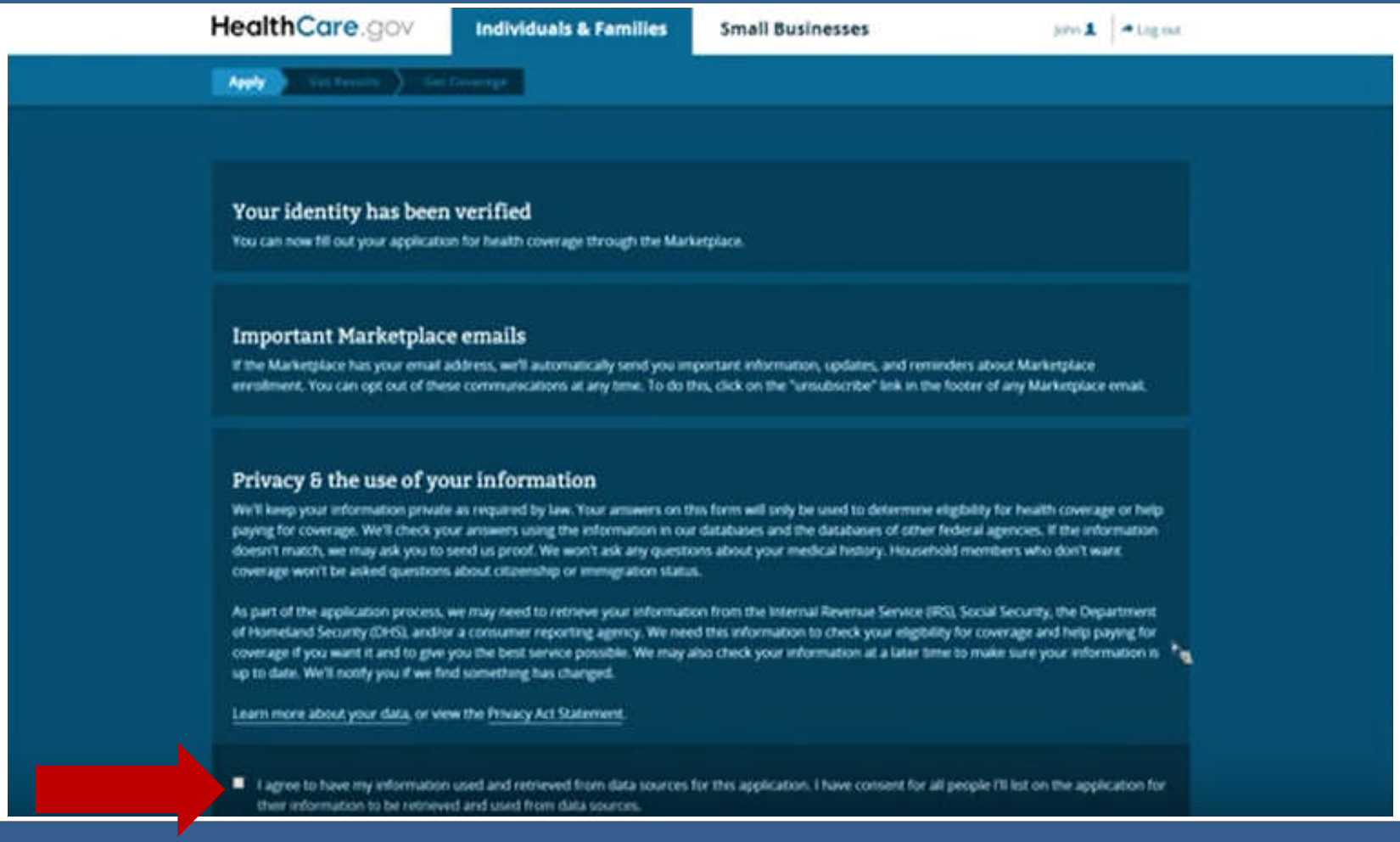
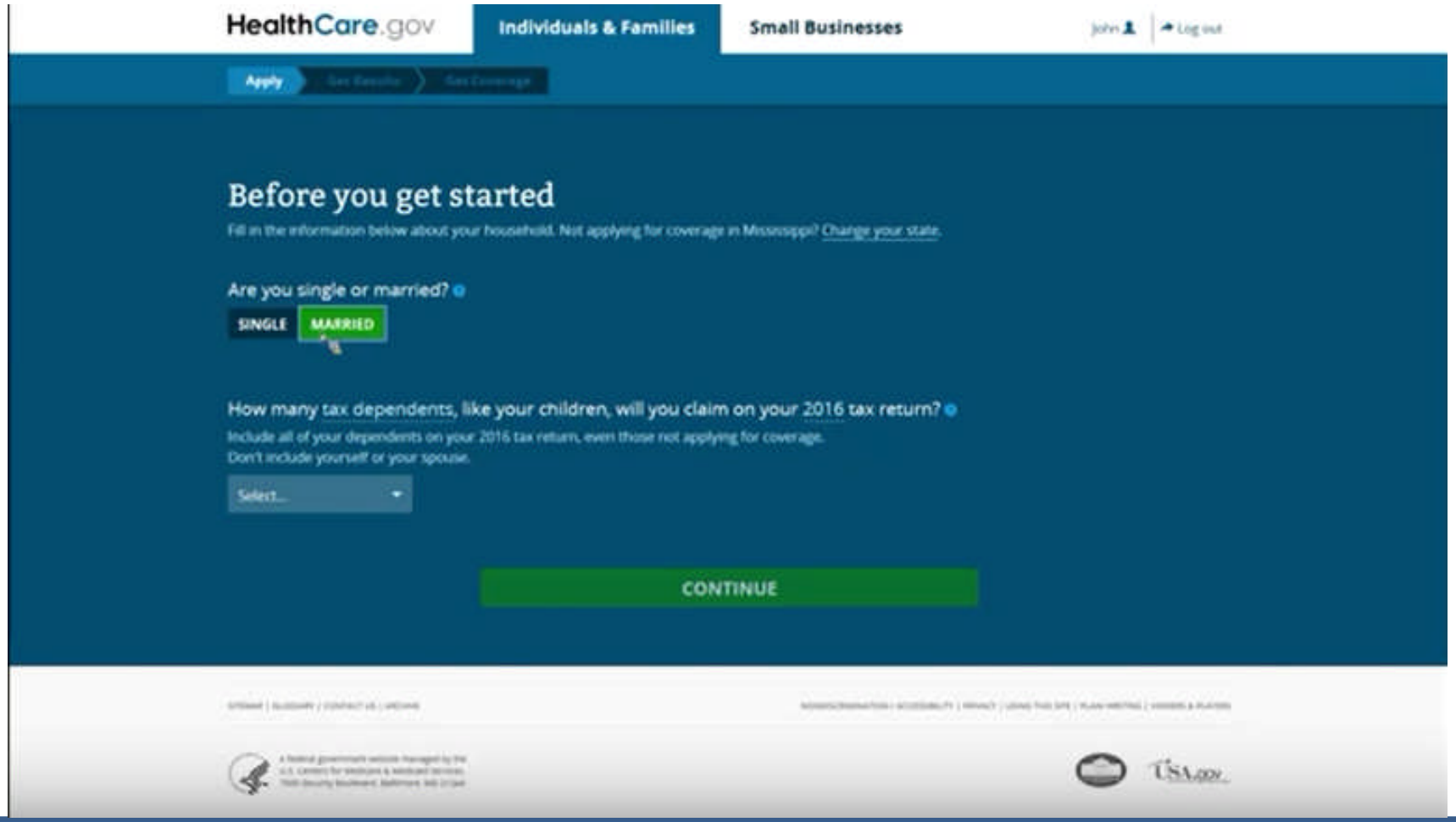


Application Process



Application Process



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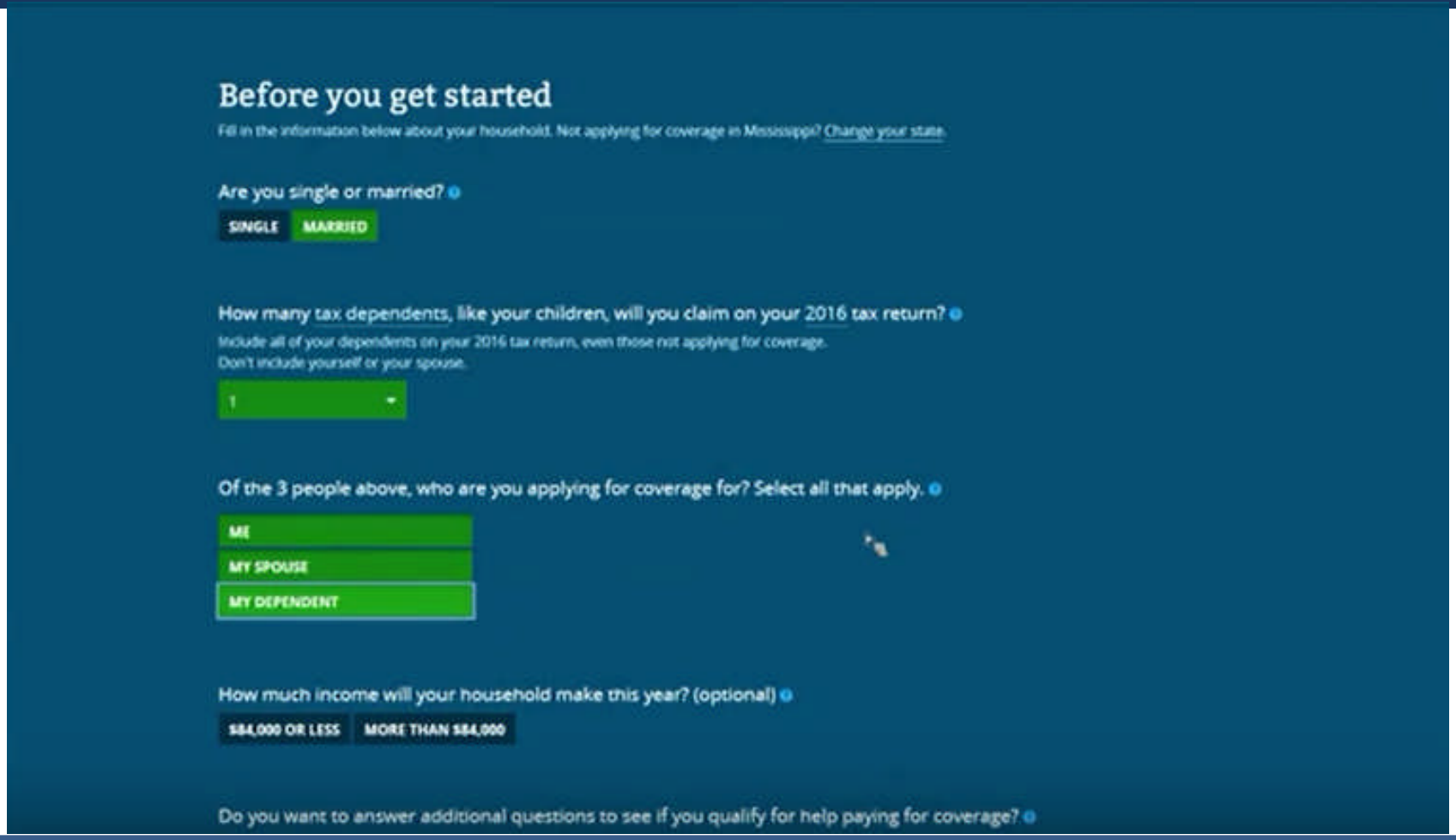
Application Process



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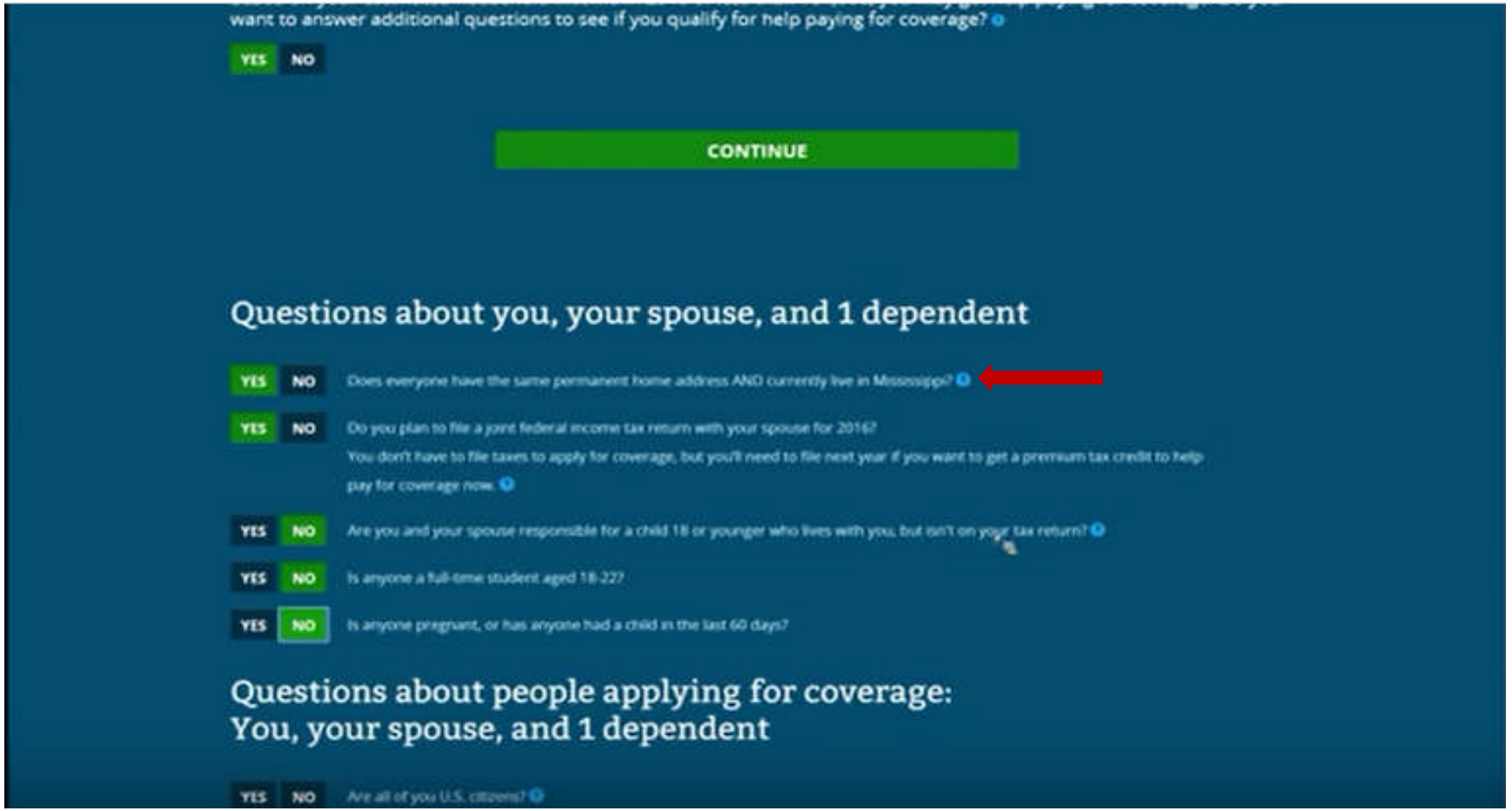

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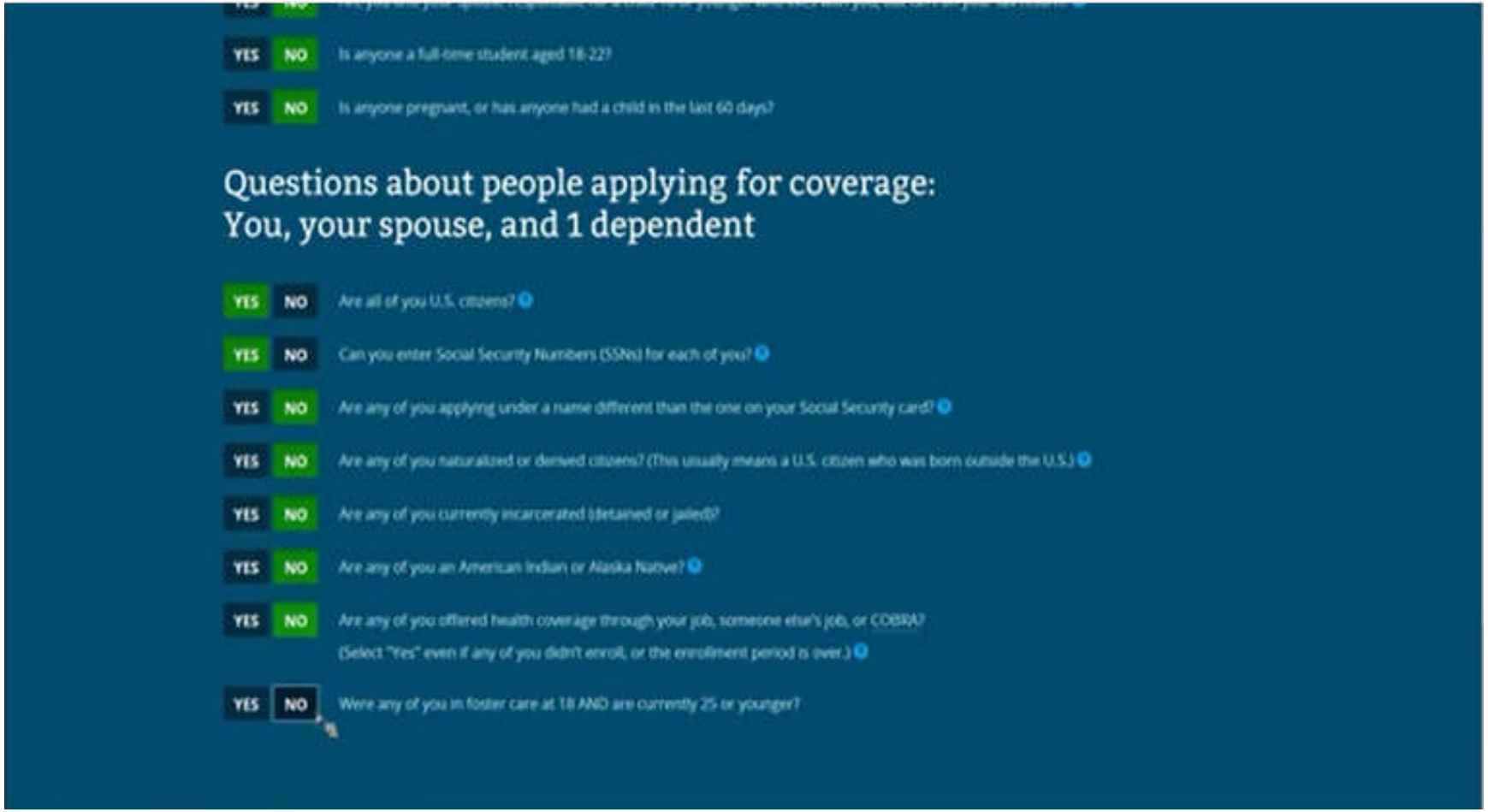

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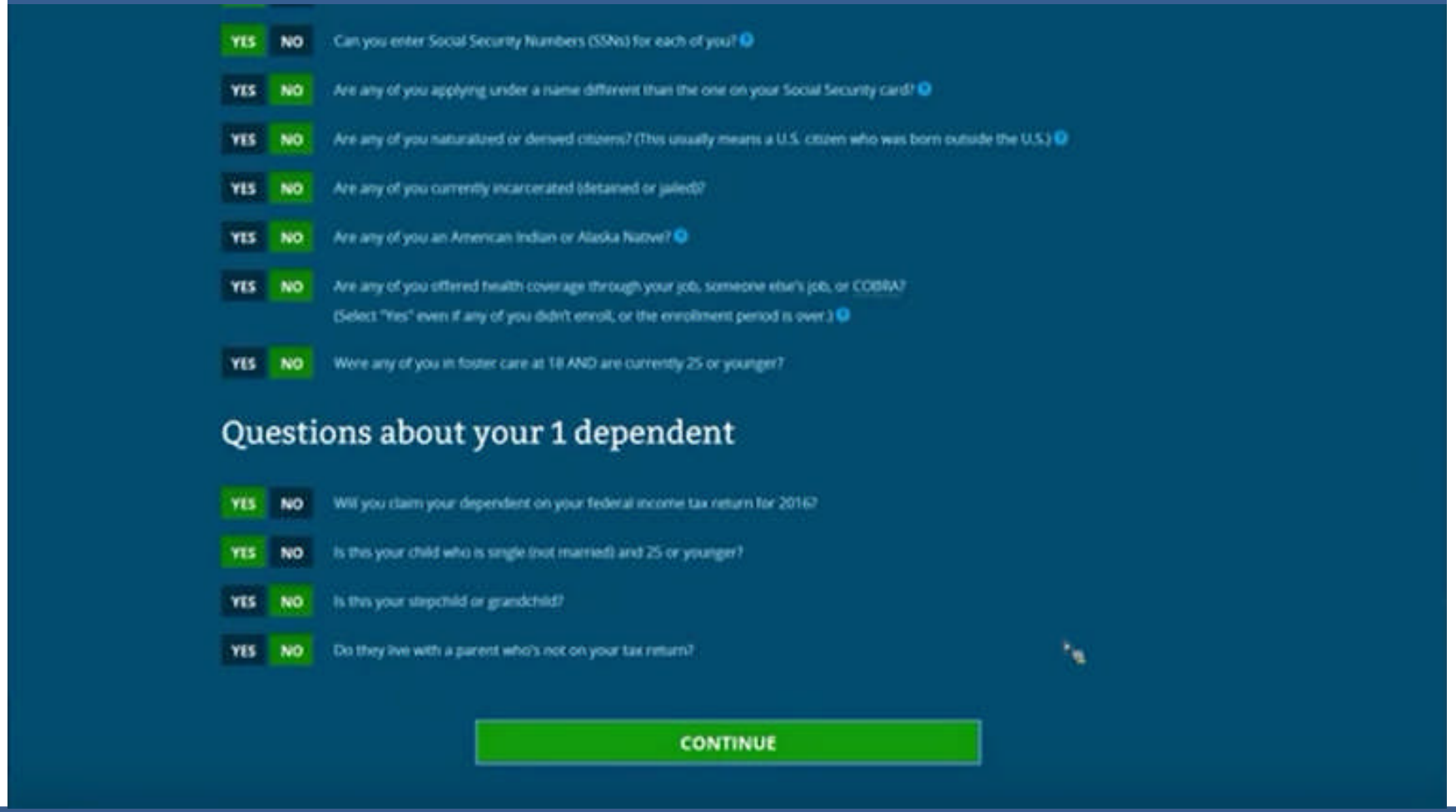

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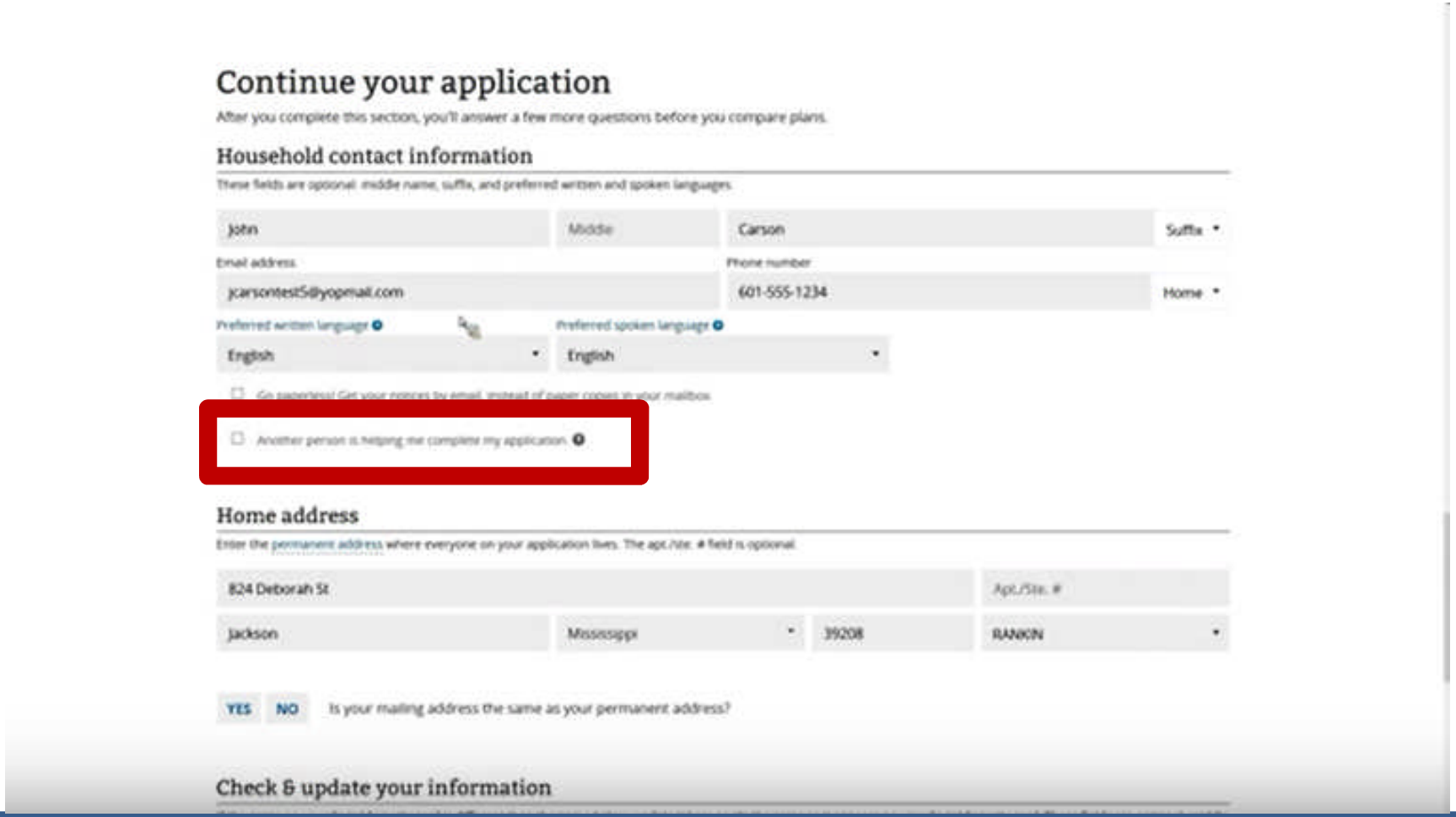

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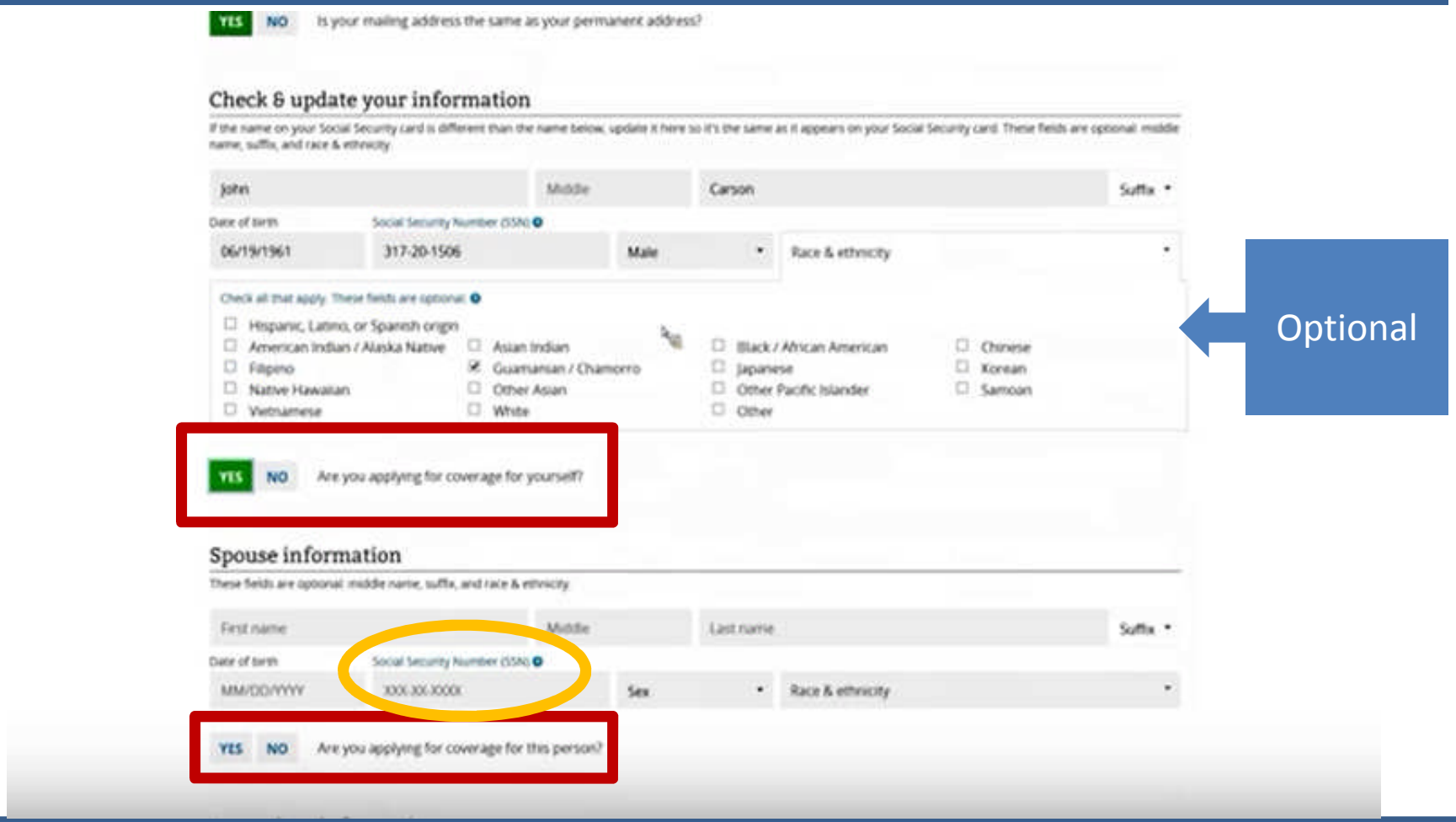
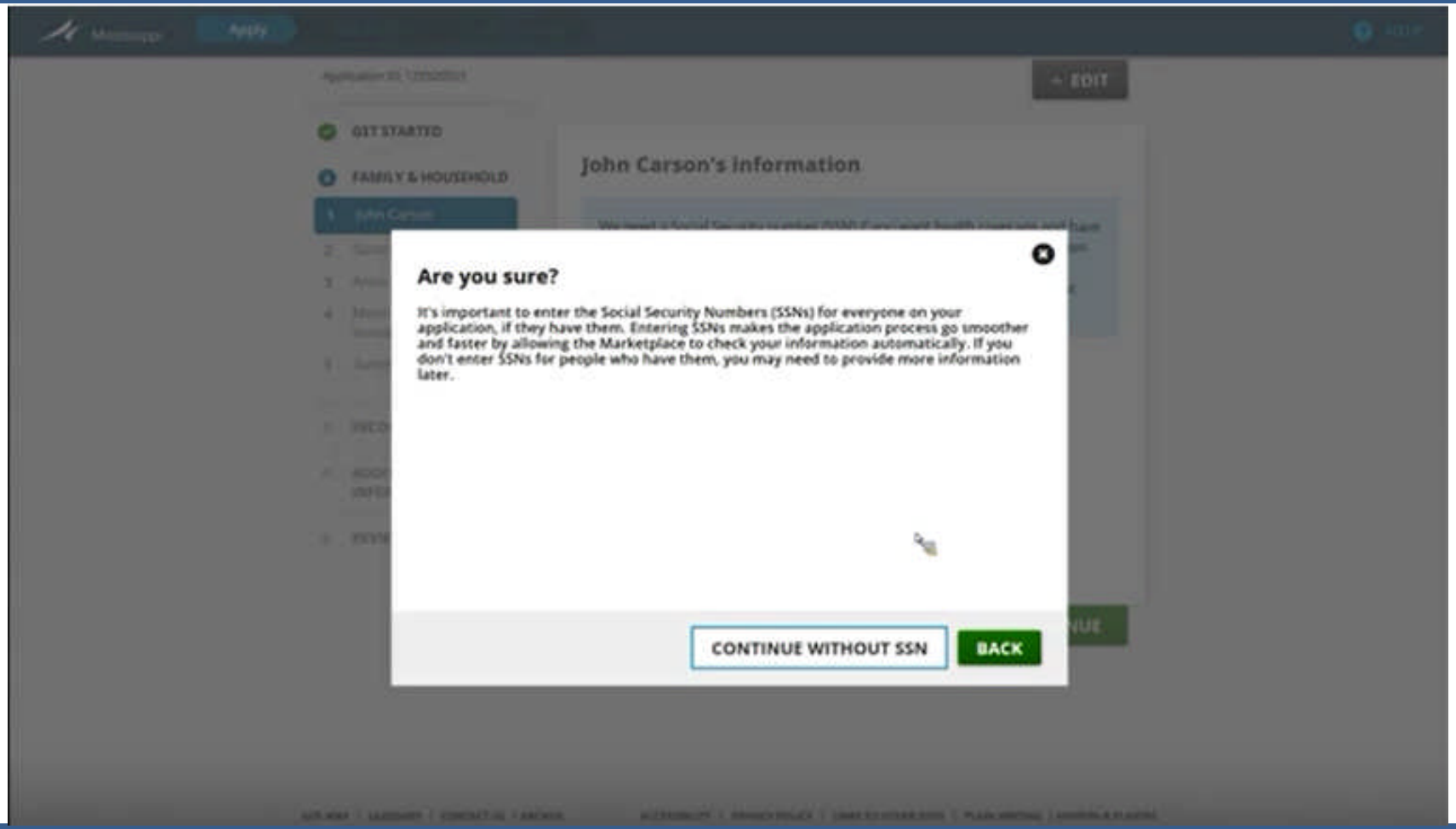


Optional

Application Process



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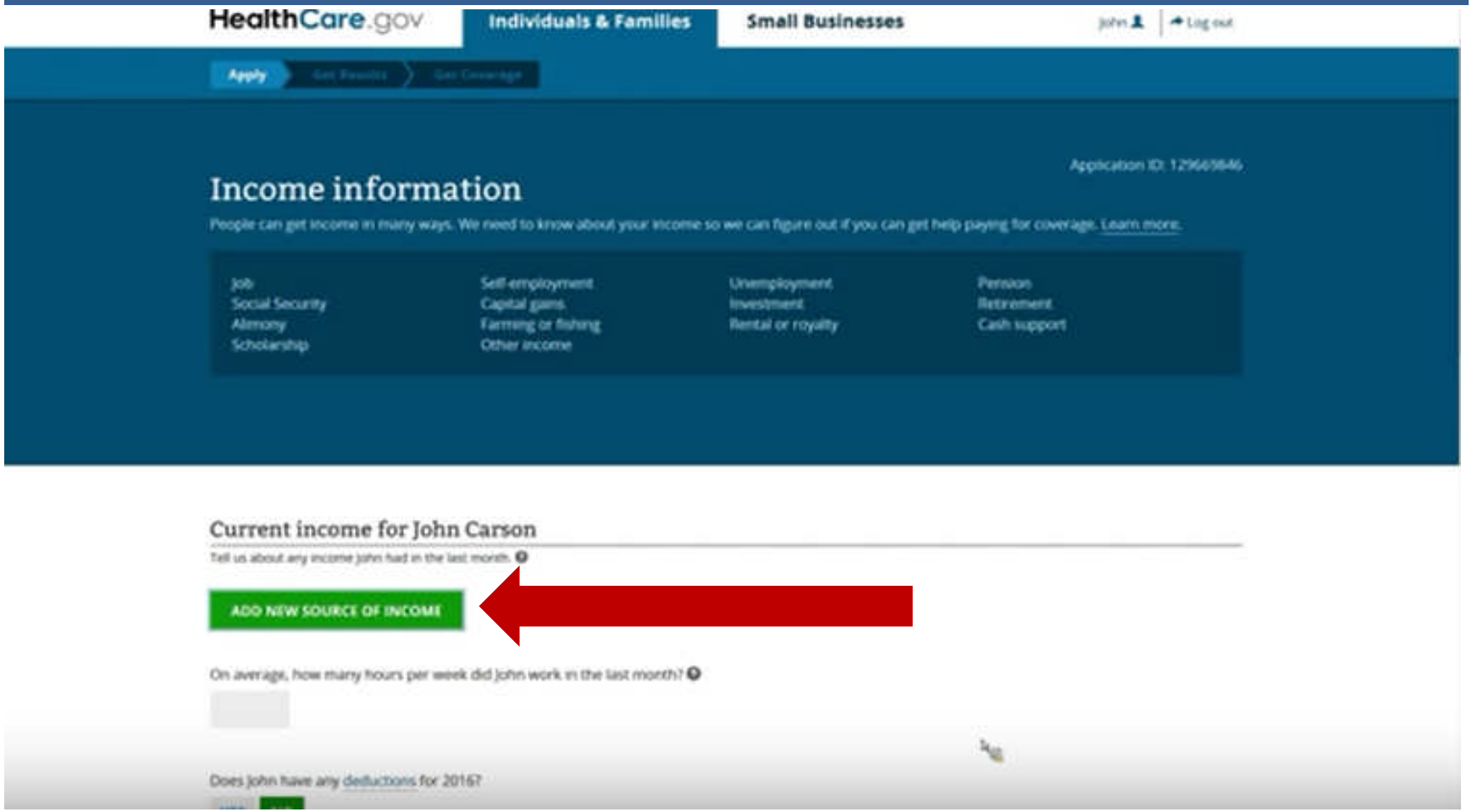

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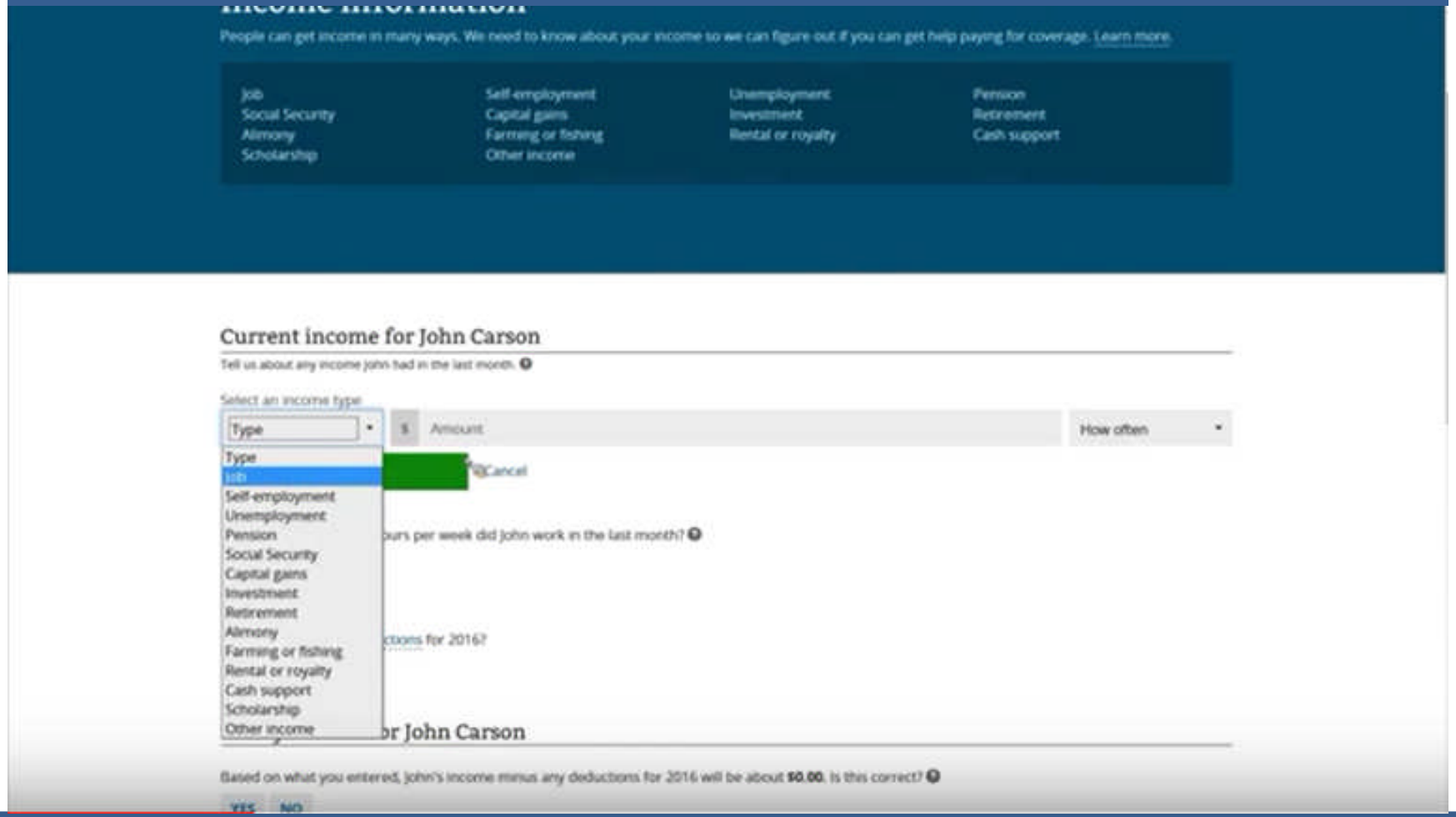


Application Process

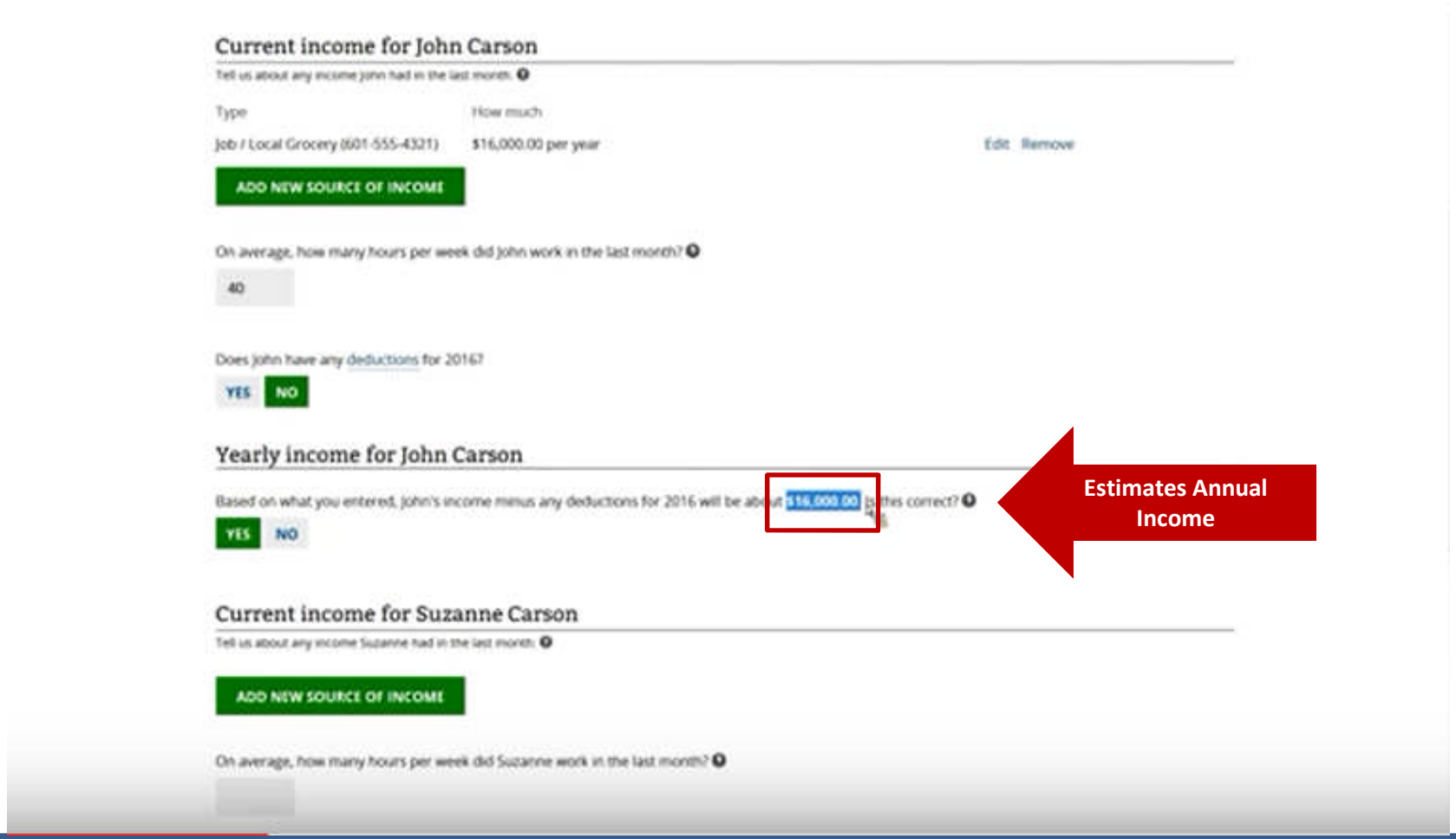
Whose income to include:
For most people, a household consists of the tax filer, their spouse if they have one, and their tax dependents, **including those who don't need coverage**.
The Marketplace counts estimated income of all household members who are required to file a tax return.

What income is counted
The Marketplace uses modified adjusted gross income (MAGI) to determine eligibility for savings.

MAGI is the total of the following for each member of a household who's required to file a tax return:

- adjusted gross income (AGI) on your federal tax return
- Excluded foreign income
- Nontaxable Social Security benefits (including tier 1 railroad retirement benefits)
- Tax-exempt interest
- MAGI **does not** include Supplemental Security Income (SSI)

Application Process



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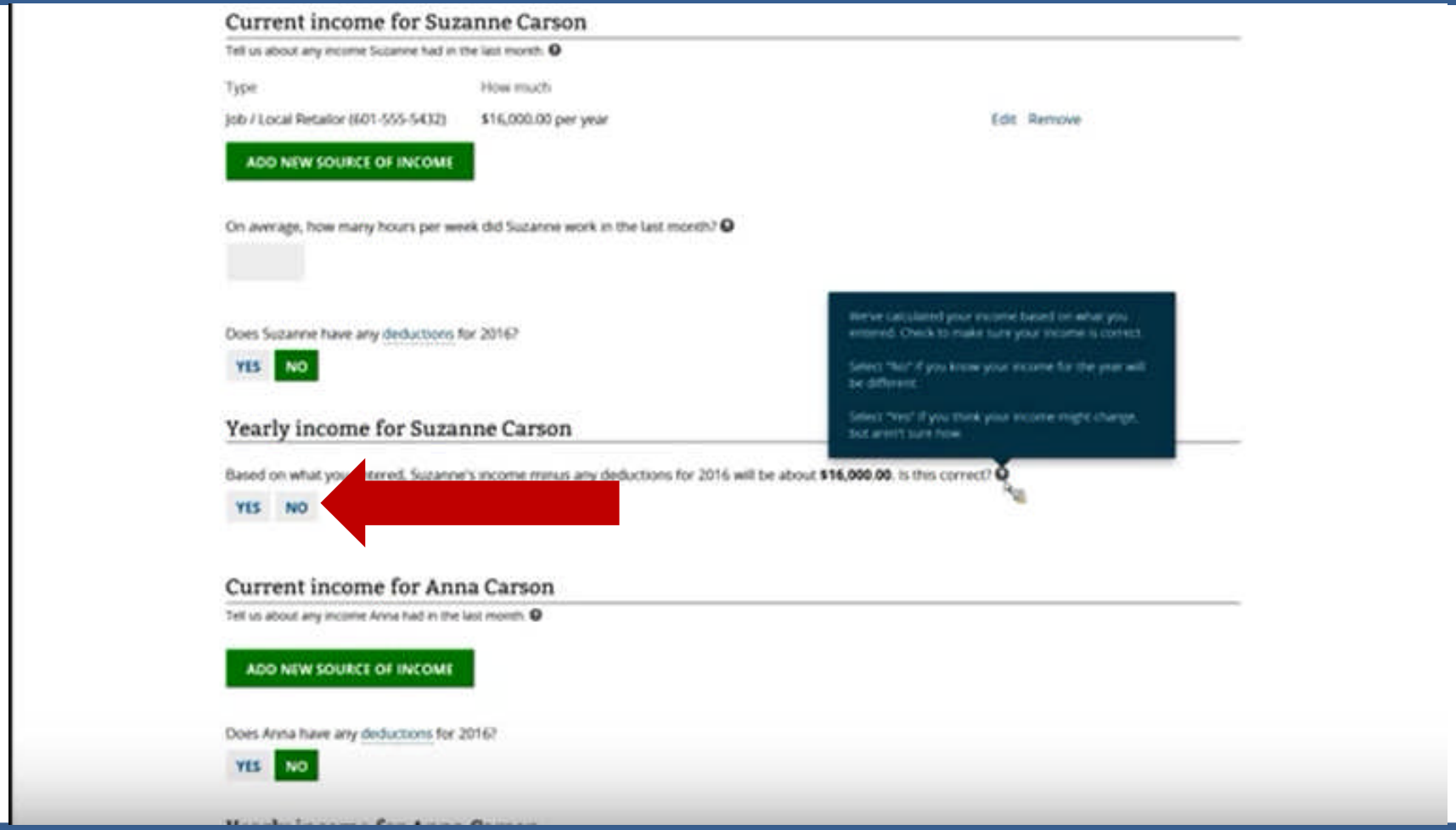

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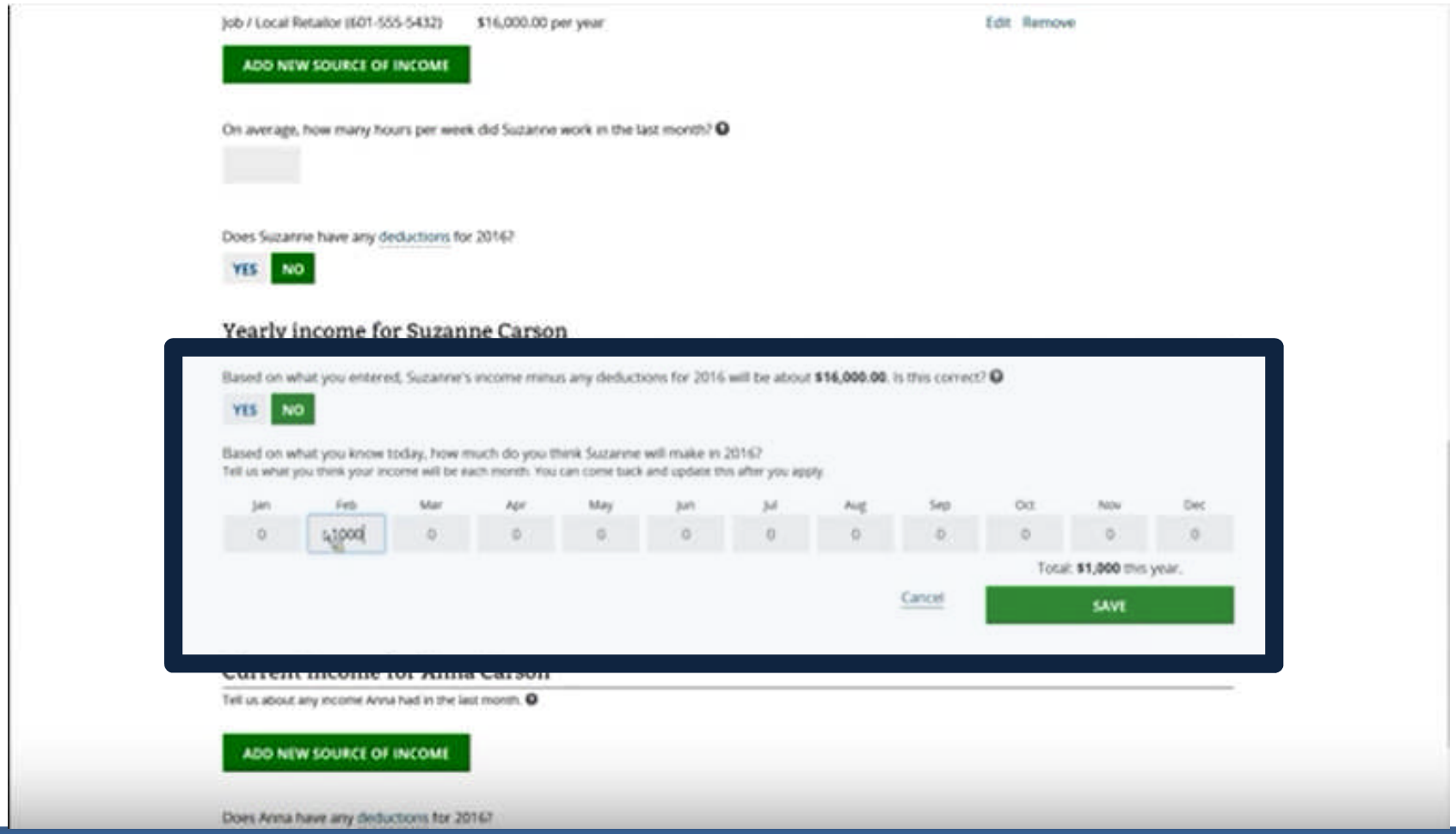

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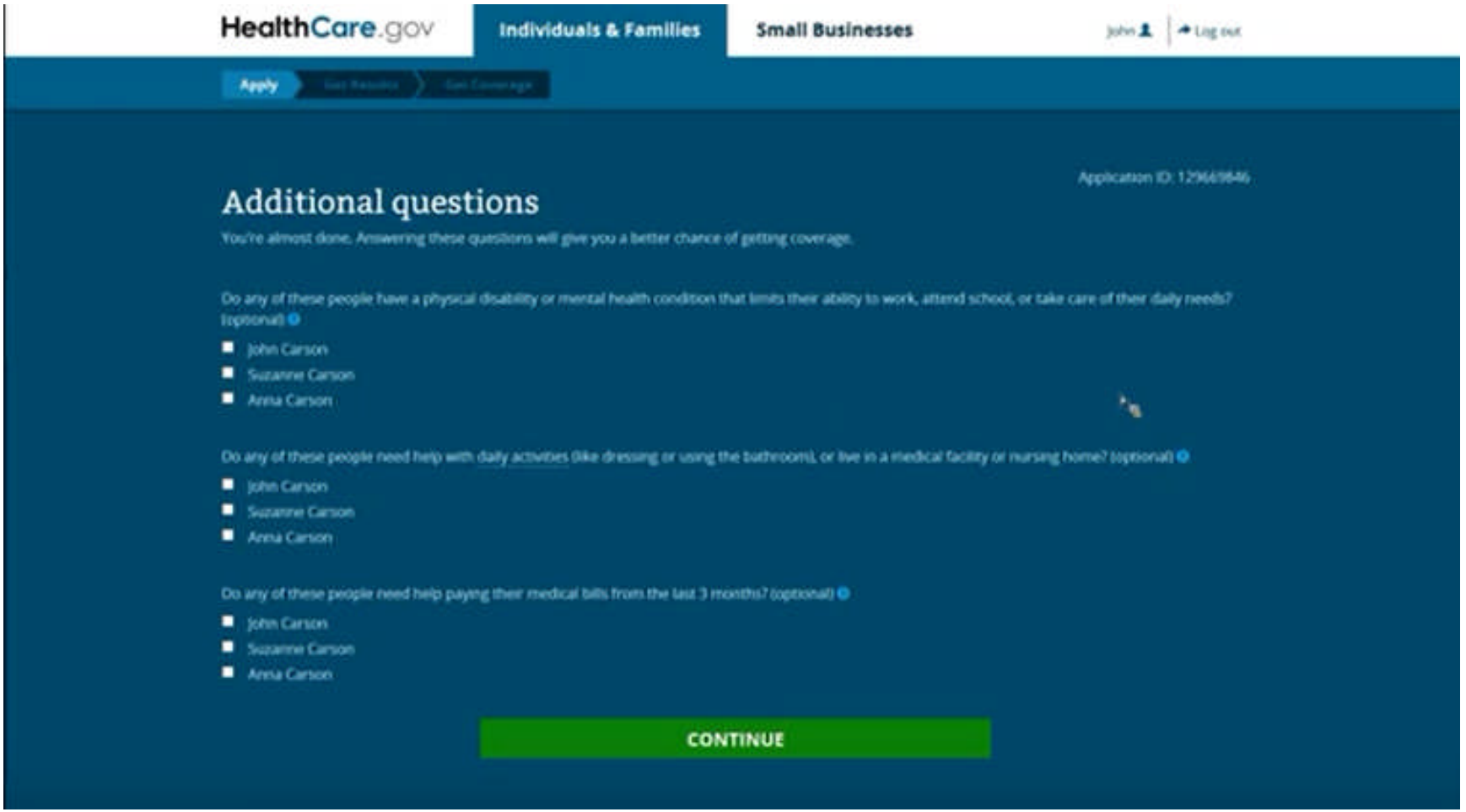
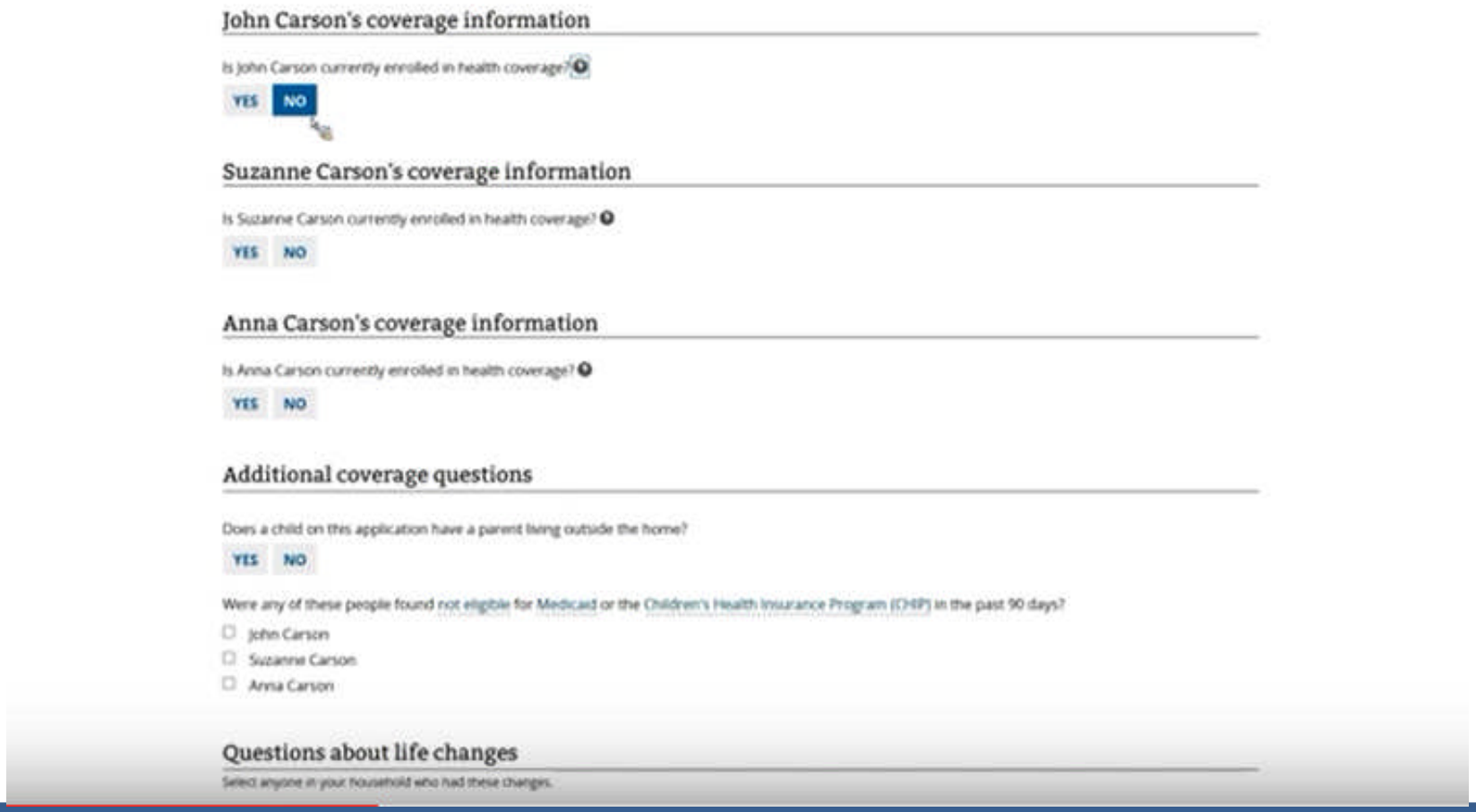


KHBE
Kentucky Health Benefit Exchange

Application Process



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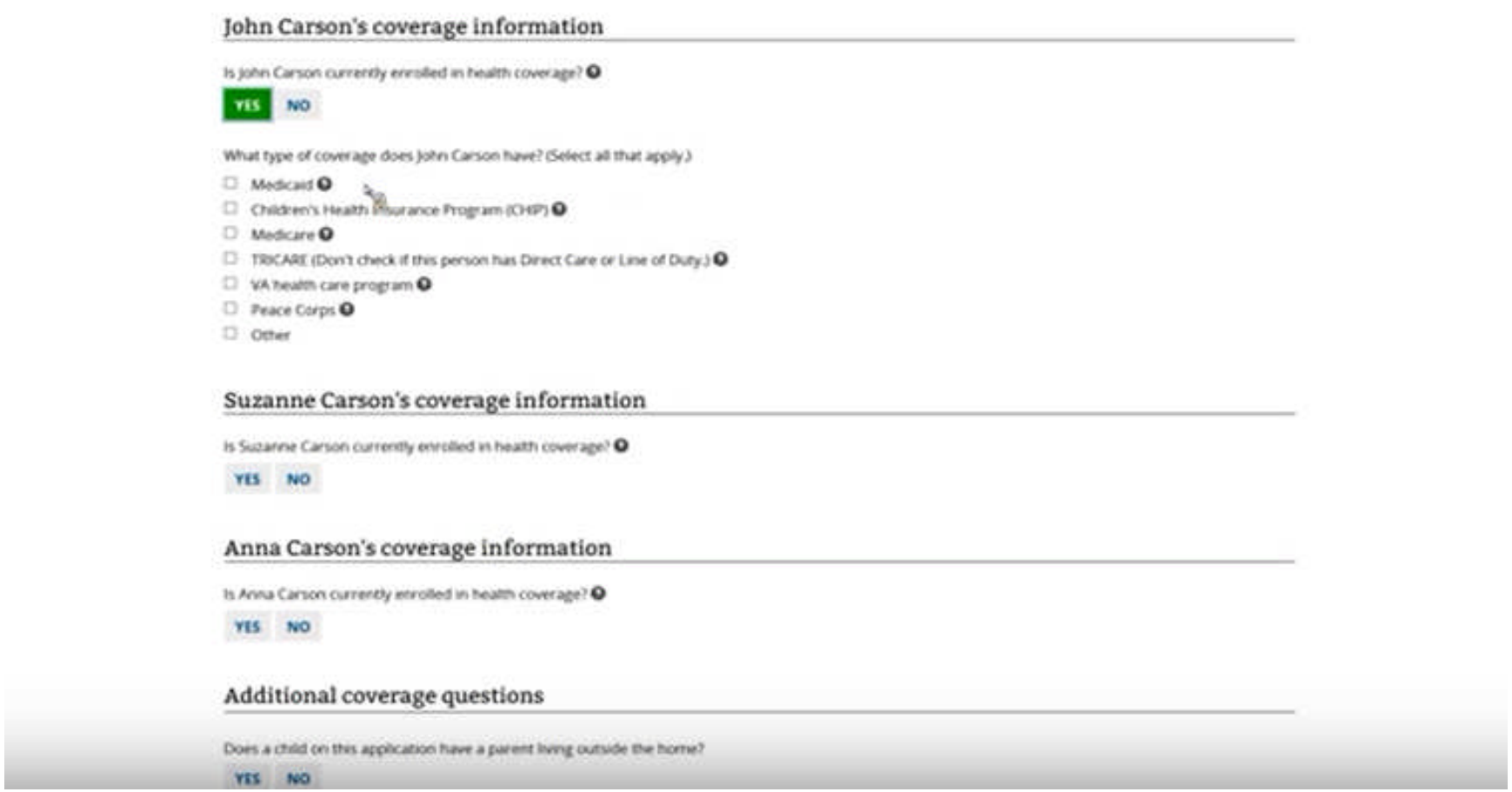

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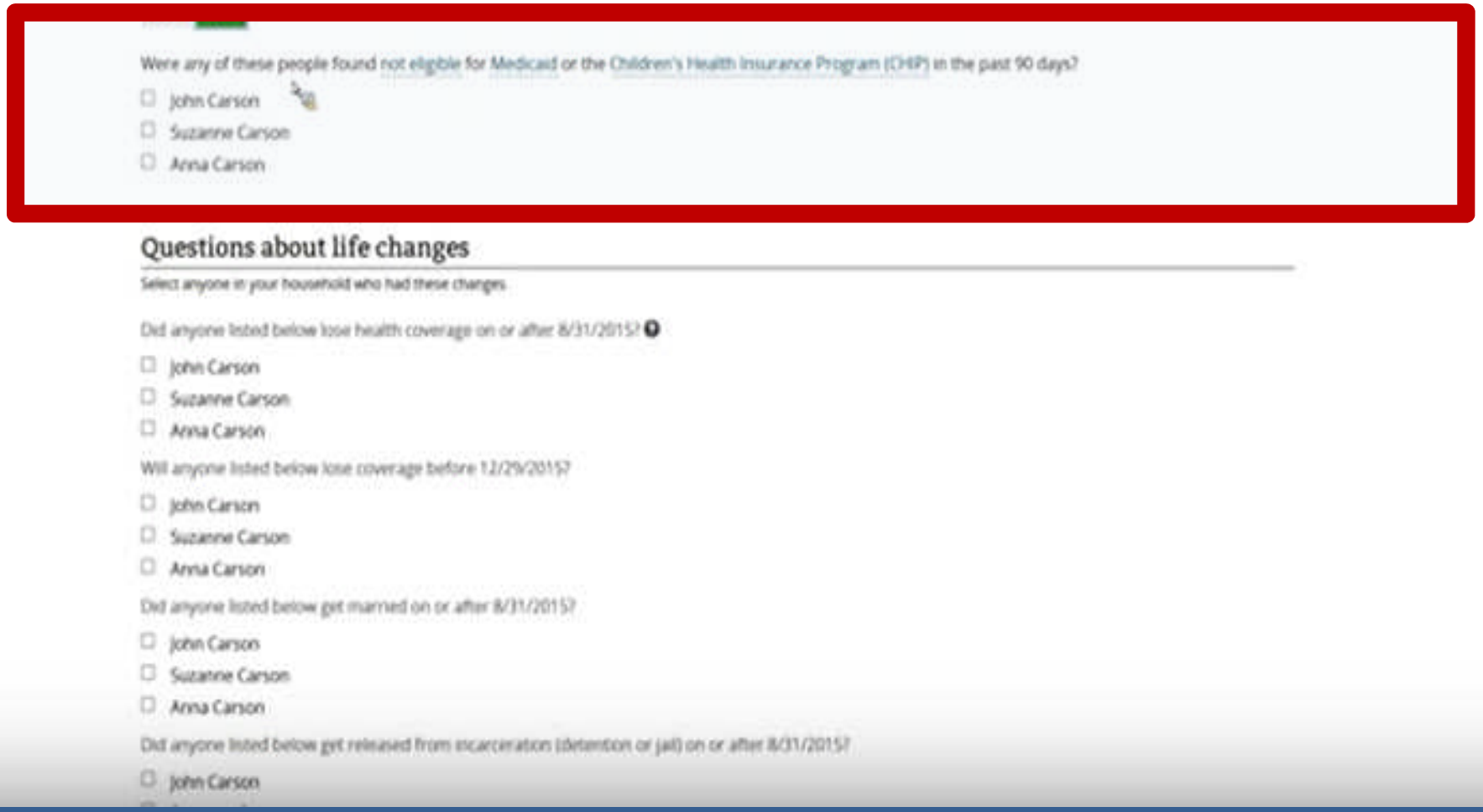

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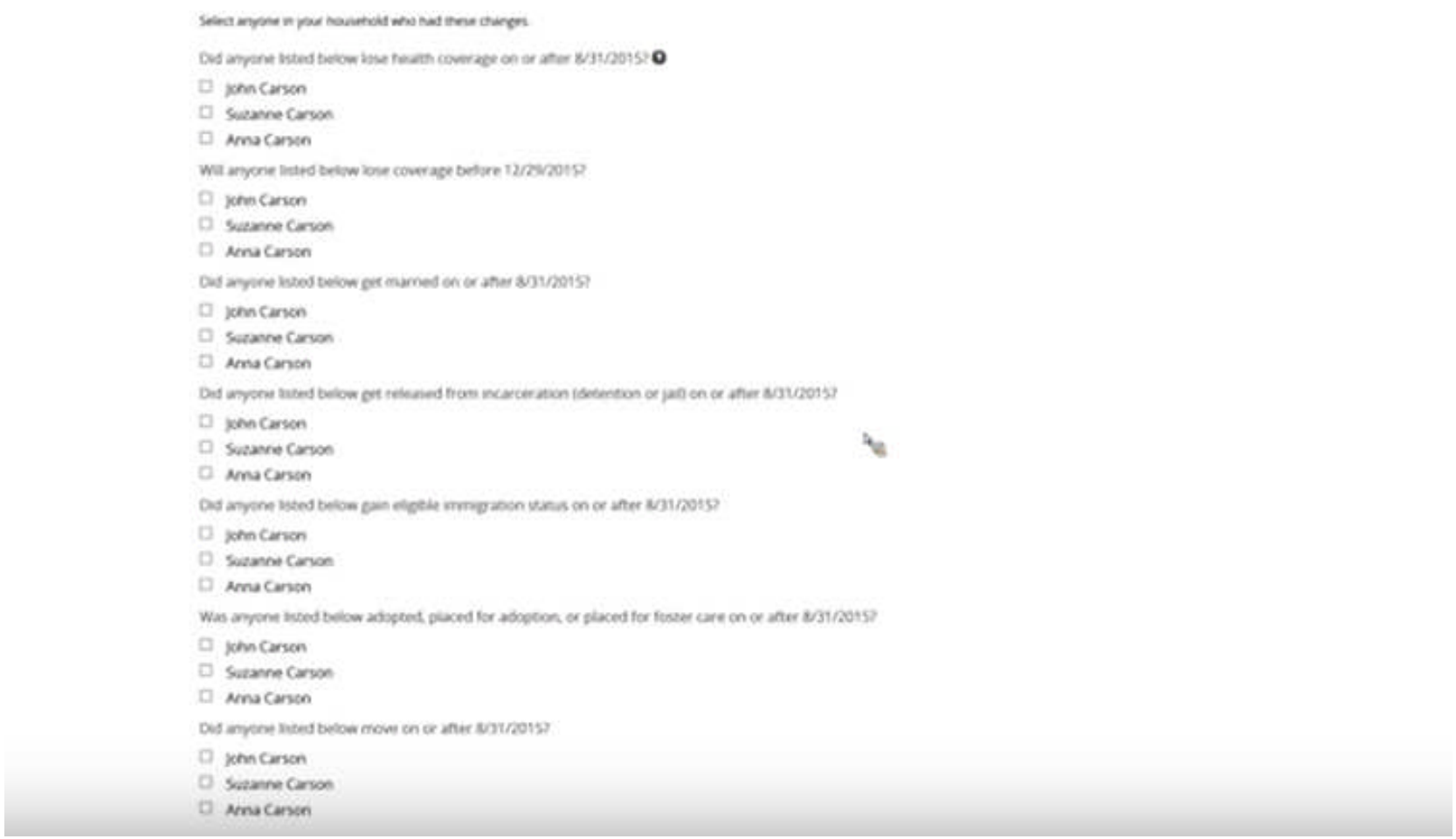

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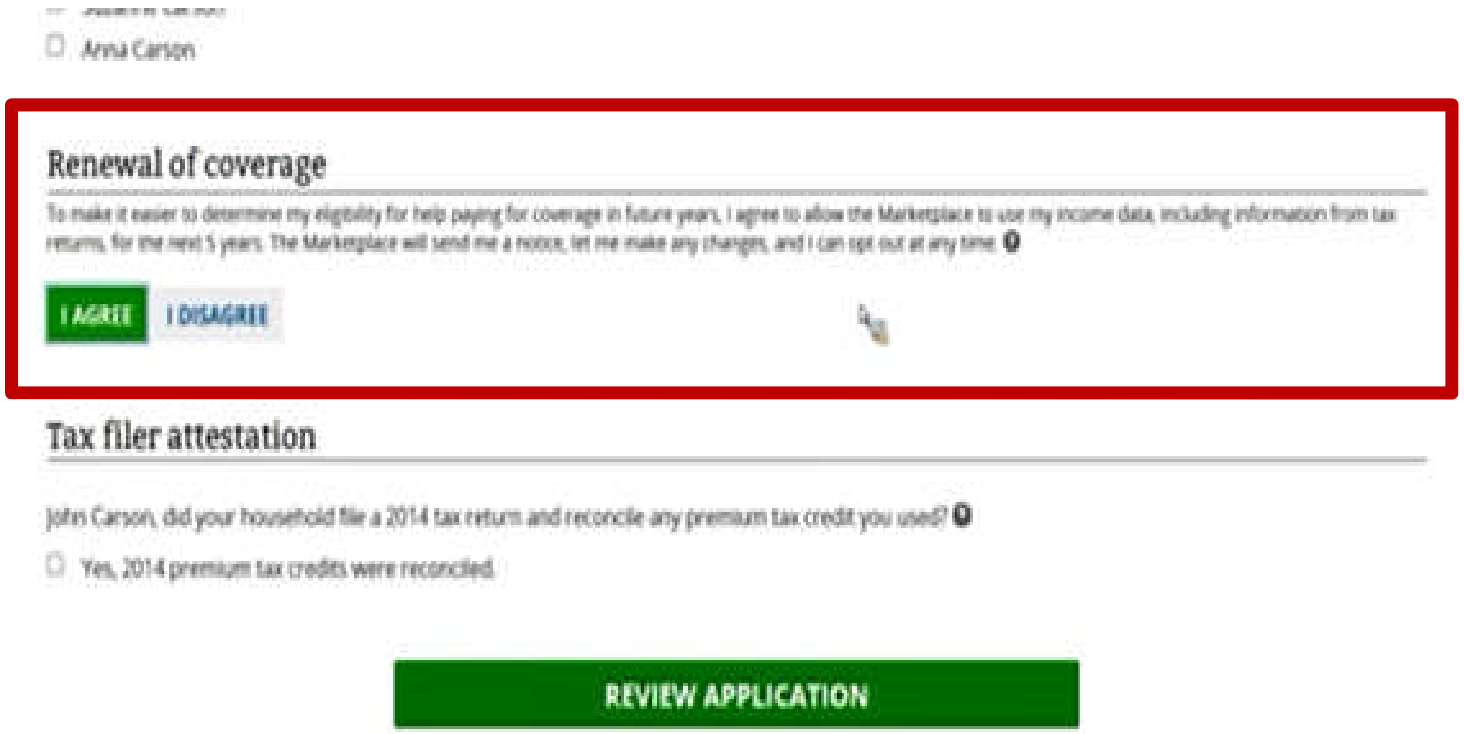

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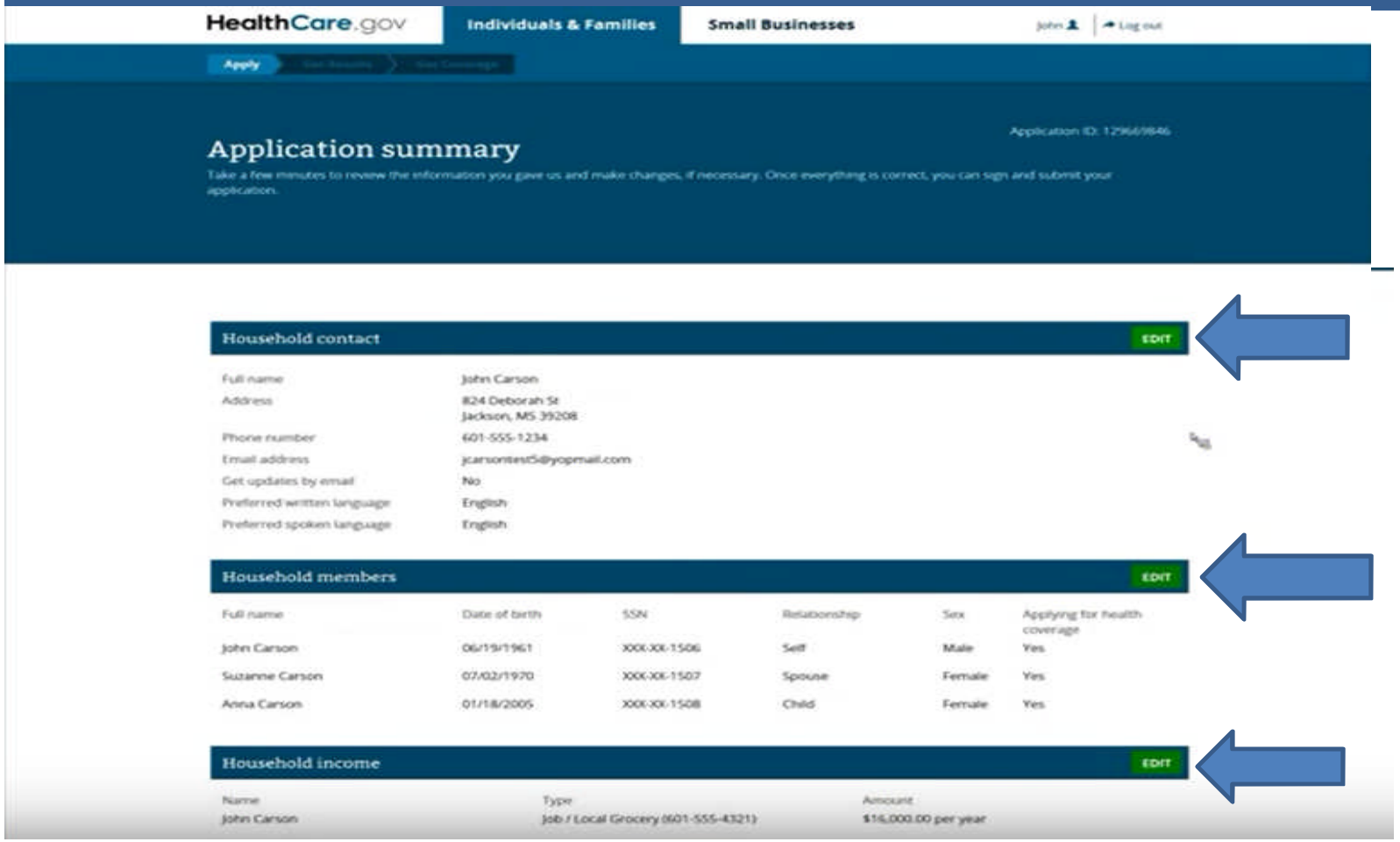

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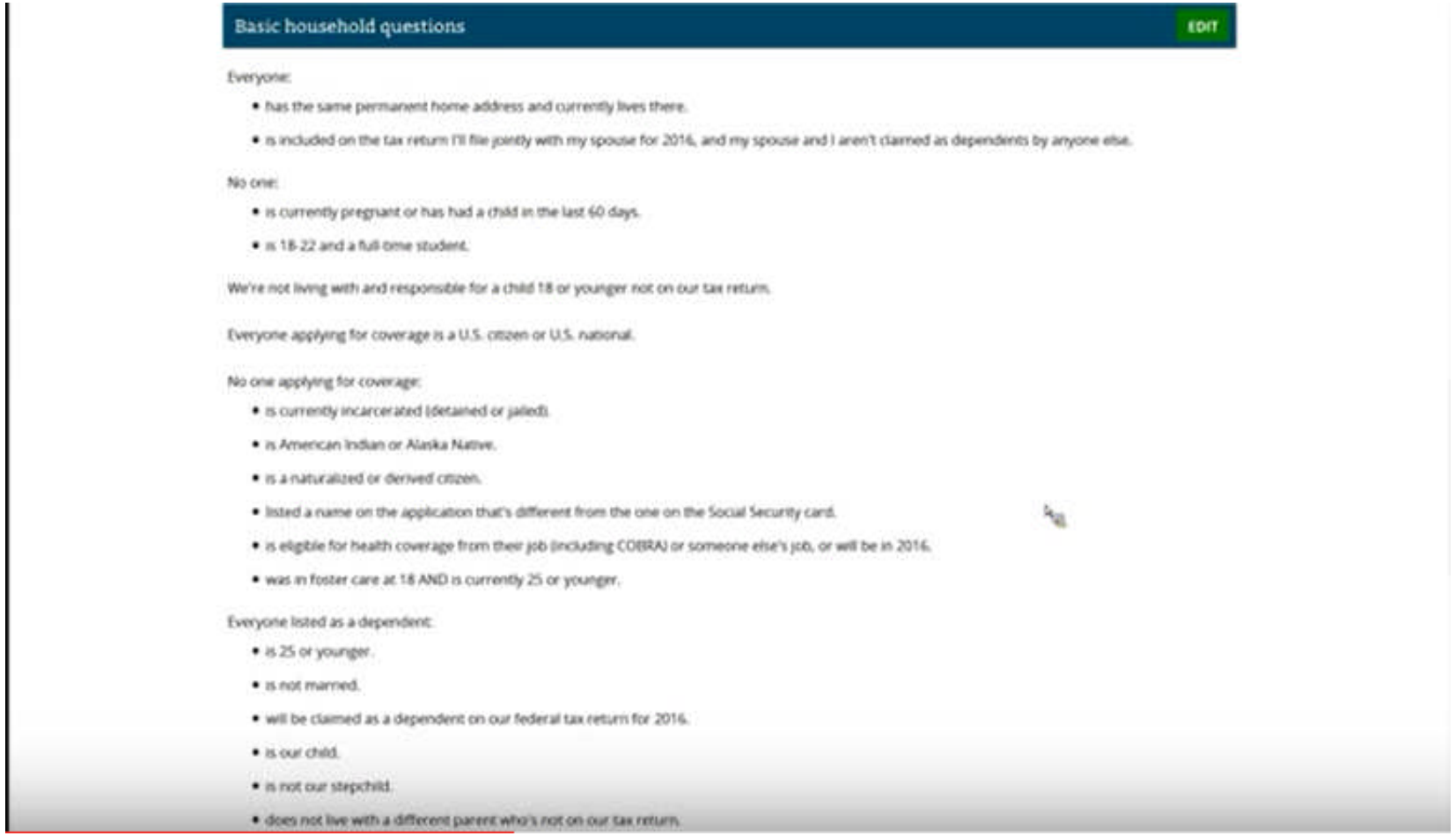


Basic household questions EDIT

Everyone:

- has the same permanent home address and currently lives there.
- is included on the tax return I'll file jointly with my spouse for 2016, and my spouse and I aren't claimed as dependents by anyone else.

No one:

- is currently pregnant or has had a child in the last 60 days.
- is 18-22 and a full-time student.

We're not living with and responsible for a child 18 or younger not on our tax return.

Everyone applying for coverage is a U.S. citizen or U.S. national.

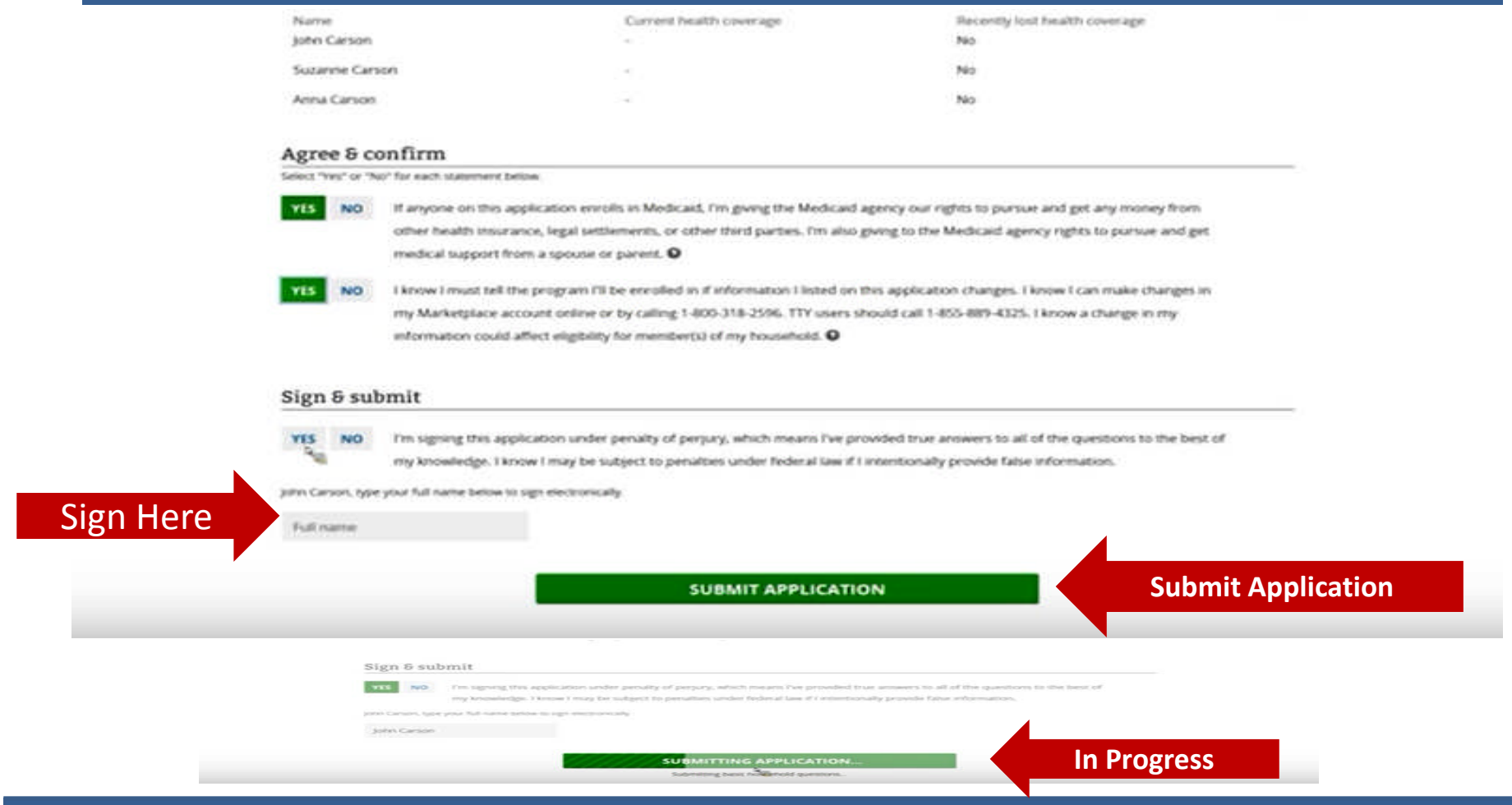
No one applying for coverage:

- is currently incarcerated (detained or jailed).
- is American Indian or Alaska Native.
- is a naturalized or derived citizen.
- listed a name on the application that's different from the one on the Social Security card.
- is eligible for health coverage from their job (including COBRA) or someone else's job, or will be in 2016.
- was in foster care at 18 AND is currently 25 or younger.

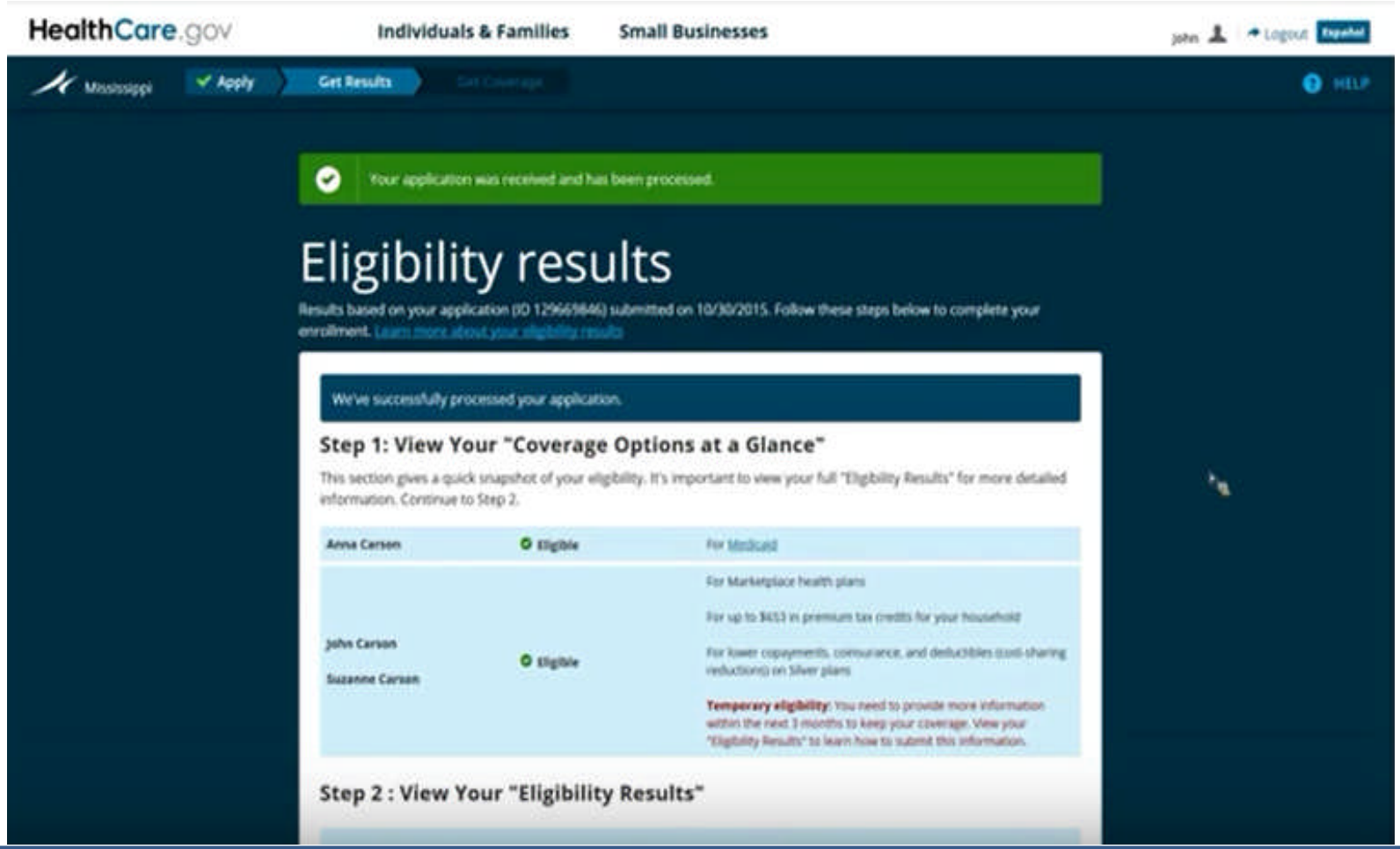
Everyone listed as a dependent:

- is 25 or younger.
- is not married.
- will be claimed as a dependent on our federal tax return for 2016.
- is our child.
- is not our stepchild.
- does not live with a different parent who's not on our tax return.

Application Process

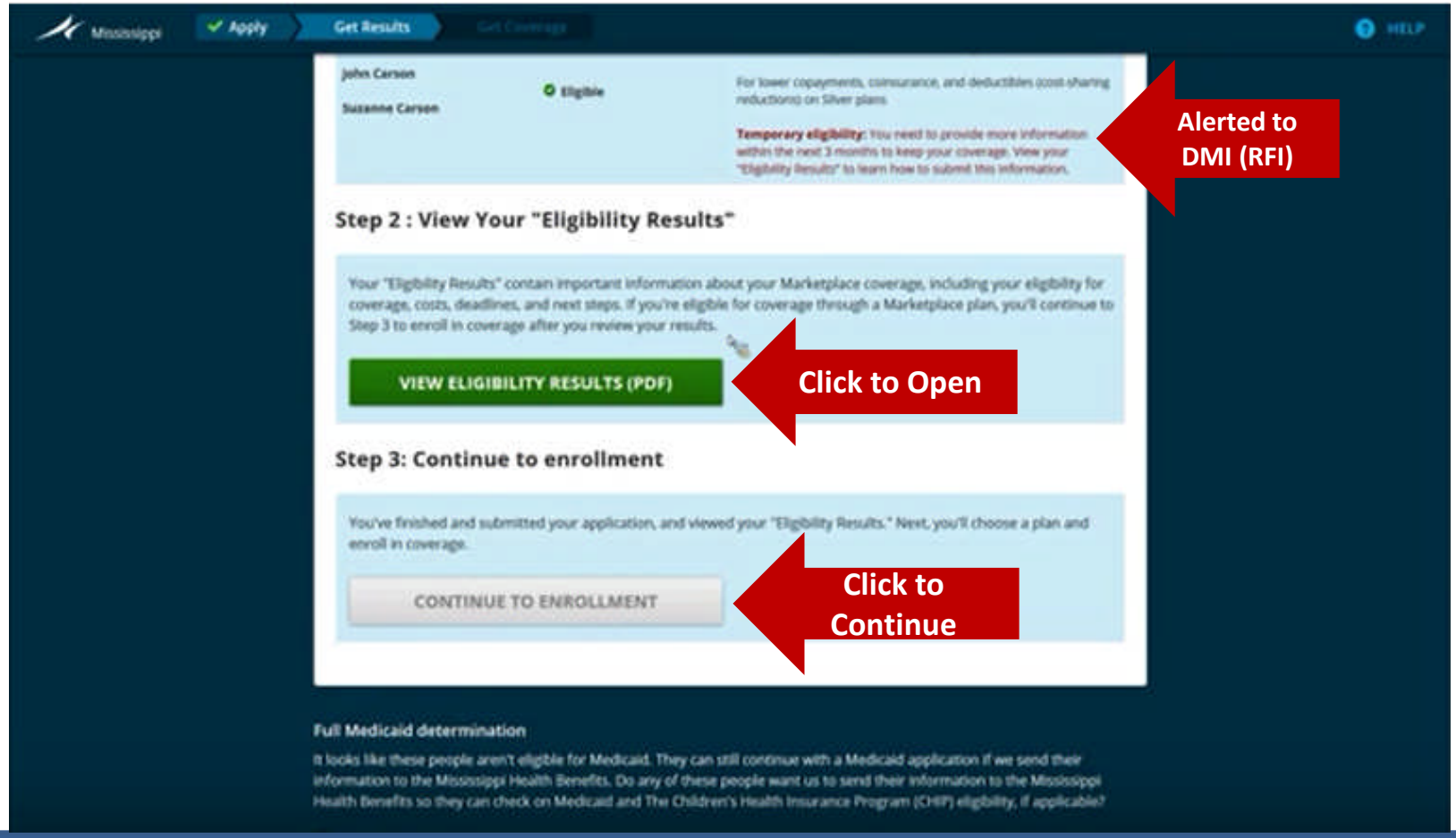


Application Process



KHBE
Kentucky Health Benefit Exchange

Application Process



Eligibility Results

Eligibility Results

At the end of the application, Eligibility results are generated immediately.

If paper application was submitted, a Notice of Eligibility will be mailed to consumer

Family member(s)	Results	Next steps
May Leon	• Eligible for a tax credit ($449.00 each month, which is $5,388.00 for the year, for your tax household), but we need more information from you. This calculation is based on the yearly household income of $30,135.00. This is the amount that you provided on your Marketplace application or the amount that came from the most recent income data sources available.	• Send the Marketplace more information
Jack Leon	• Can choose a health plan with lower copayments, coinsurance, and deductibles (06) • Eligible to purchase health coverage through the Marketplace • Eligible for a tax credit ($449.00 each month, which is $5,388.00 for the year, for your tax household), but we need more information from you. This calculation is based on the yearly household income of $30,135.00. This is the amount that you provided on your Marketplace application or the amount that came from the most recent income data sources available.	• Choose a health plan and make first month's payment • Send the Marketplace more information

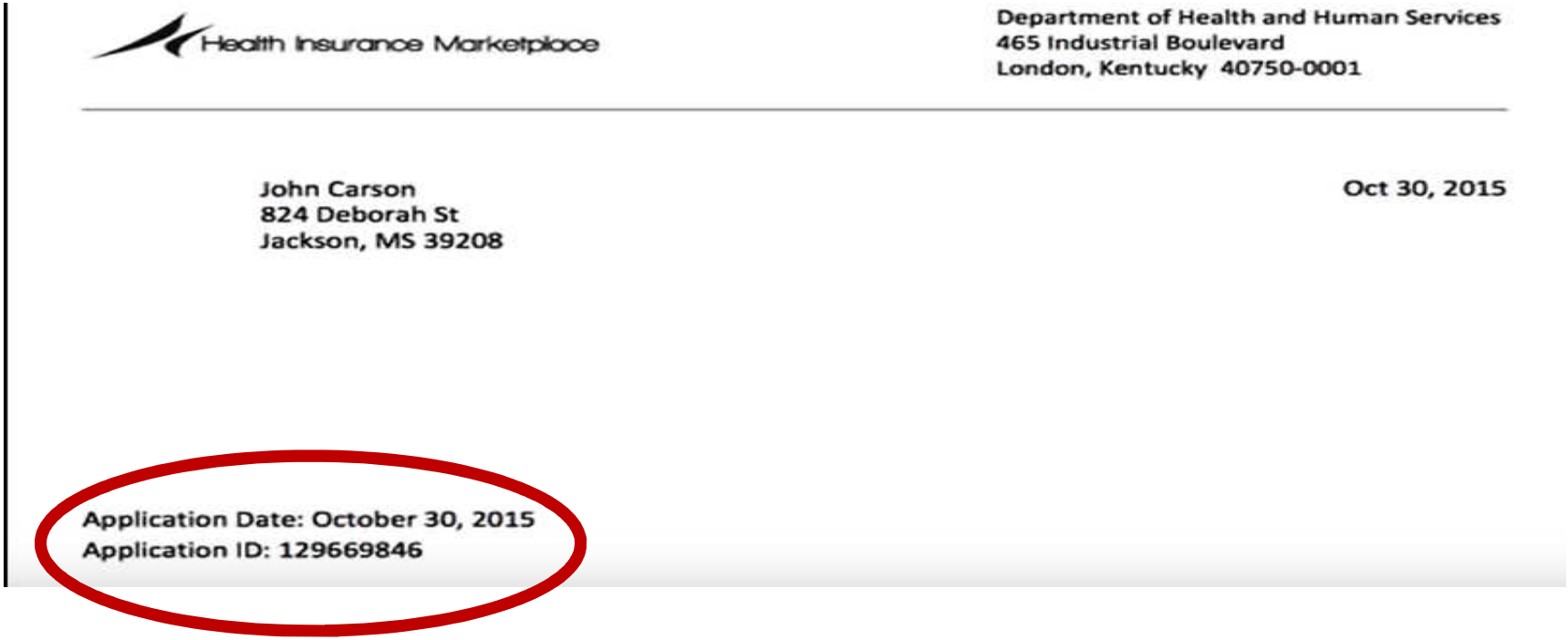
Mixed Eligibility

Mixed Eligibility

Eligibility Notice will indicate what program each person on the application is qualified for and indicate any next steps

Jack Leon	• Can choose a health plan with lower copayments, coinsurance, and deductibles (06) • Eligible to purchase health coverage through the Marketplace • Eligible for a tax credit ($449.00 each month, which is $5,388.00 for the year, for your tax household), but we need more information from you. This calculation is based on the yearly household income of $30,135.00. This is the amount that you provided on your Marketplace application or the amount that came from the most recent income data sources available.	• Choose a health plan and make first month's payment • Send the Marketplace more information
Tommy Leon	• May be eligible for Medicaid. This calculation is based on the monthly household income of $2,511.25 that you provided on your Marketplace application.	• You will receive a final decision from the [Medicaid agency name]. If you qualify for Medicaid, you won't qualify for a tax credit and lower copayments, coinsurance, and deductibles for Health Insurance Marketplace coverage.

Application Process



Health Insurance Marketplace

Department of Health and Human Services
465 Industrial Boulevard
London, Kentucky 40750-0001

John Carson
824 Deborah St
Jackson, MS 39208

Oct 30, 2015

Application Date: October 30, 2015
Application ID: 129669846

Application Process

What should I do next?

Here's what each person in your household needs to do to take the "Next steps" shown in your **Eligibility Results**. If your "Next steps" tell you to send more information, follow instructions for sending it. If you don't, you could lose what you qualify for now because your information doesn't match the data we have, or we can't verify all of the information in your application.

When will Marketplace coverage begin?

If you're eligible to buy a Marketplace plan, your plan's coverage start date depends on the date you select your plan.

What if information from my application changes during the year?

If your circumstances change and the information you gave us when you applied is no longer correct, you need to let us know within 30 days of the change. Changes may affect your eligibility for:

- Premium tax credits
- Enrollment in a plan with lower copayments, coinsurance, and deductibles
- Coverage through [state Medicaid name] or [state CHIP name]

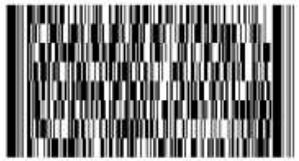
What should I do if I think my Eligibility Results are wrong?

If you have received a final determination and you think we made a mistake, in many cases, you can appeal our decision about your eligibility for health coverage, including Medicaid, CHIP, purchasing health coverage through the Marketplace, a tax credit, cost-sharing reductions, and enrollment periods.

Below is important information to consider when requesting an appeal:

Application Process

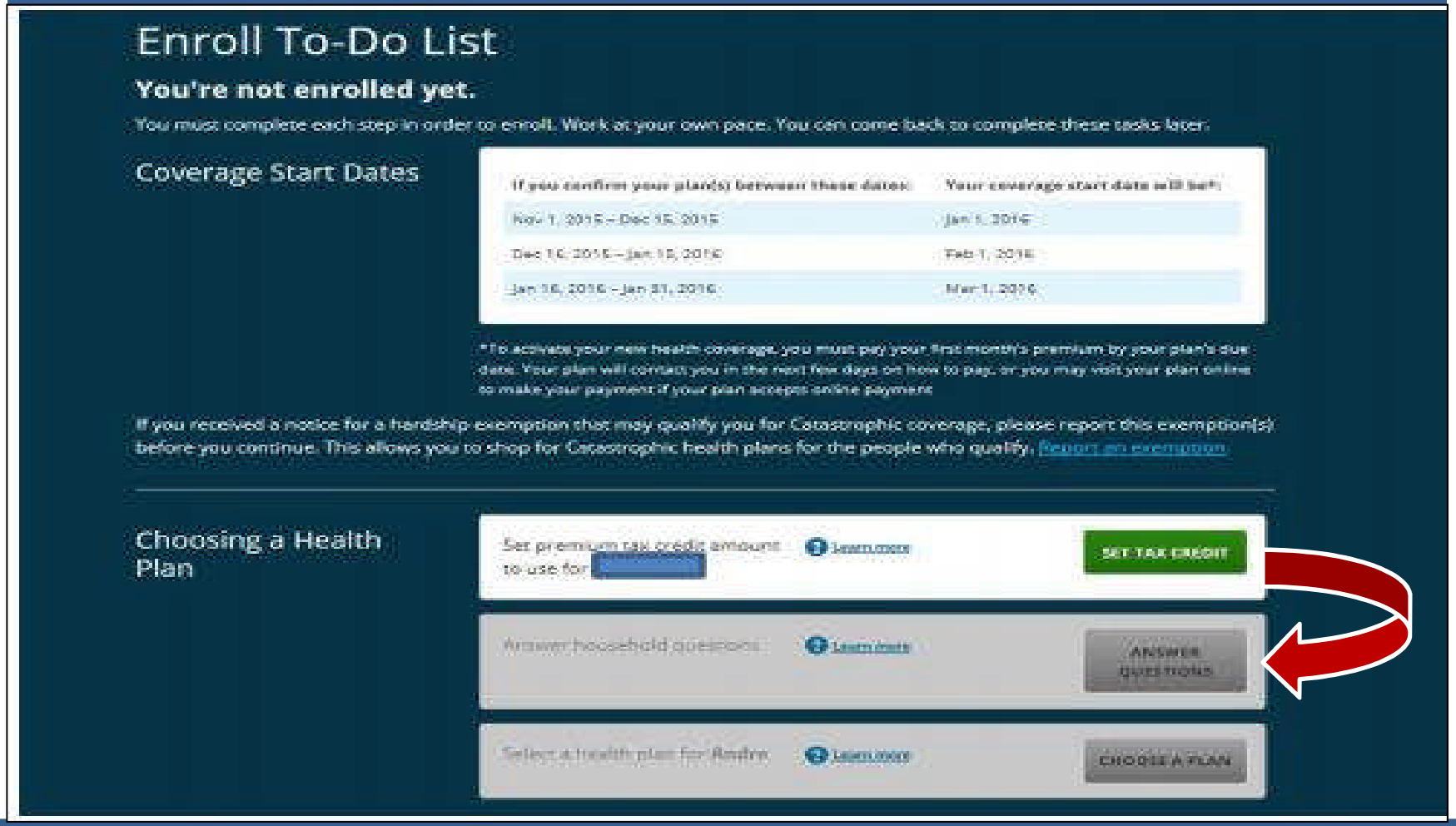
Need to send documentation? If your **Eligibility Results** say that you need to send more information, please also include a copy of this bar code page. This page helps the Marketplace make sure your documents can be easily associated with your application. For more information about choosing documents and uploading or mailing them to the Marketplace, see "8. How to send more information" in "Understanding Your Eligibility Results" included with this notice.



[State],129990294

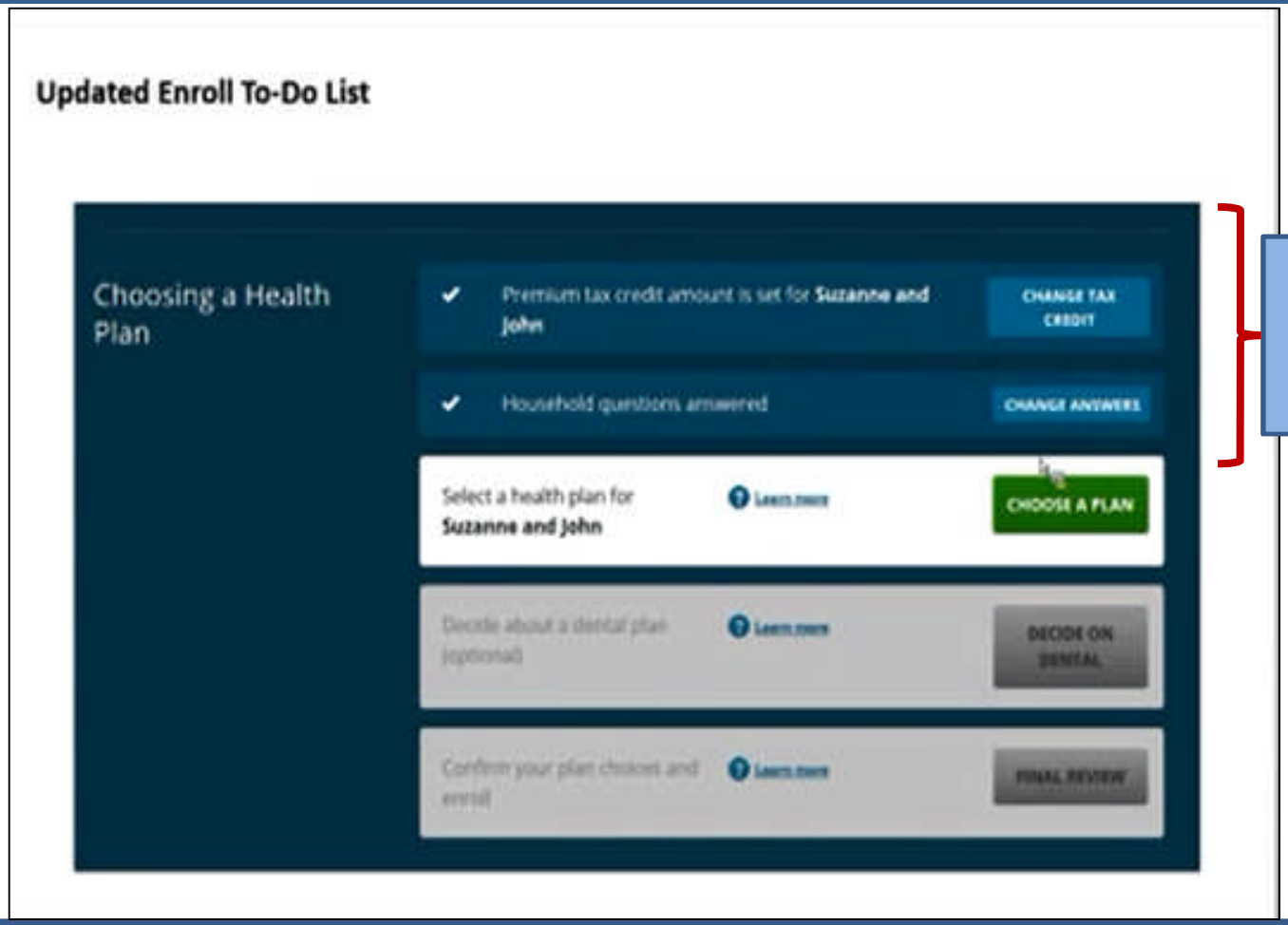
The Barcode

Application Process

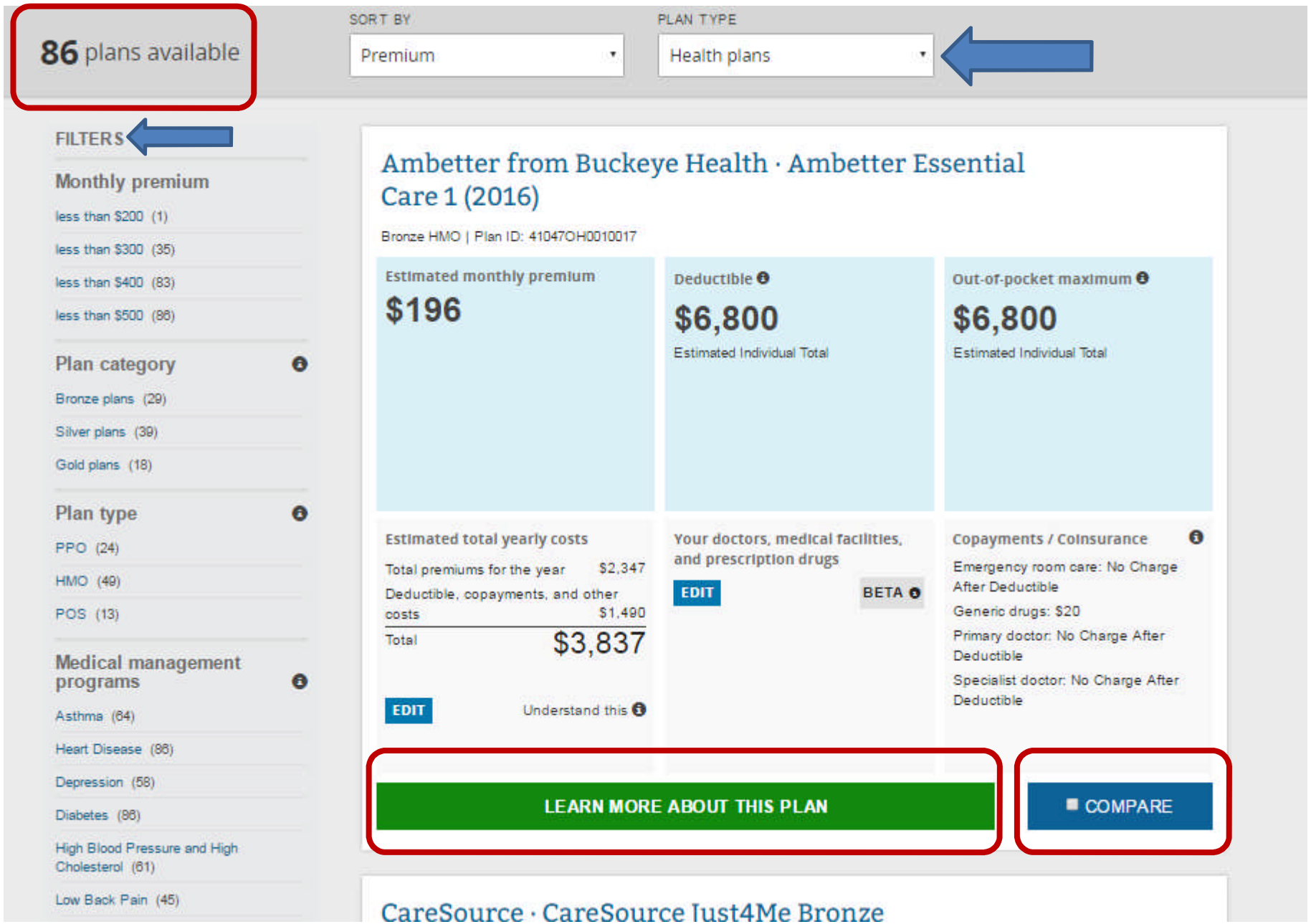


KHBE
Kentucky Health Benefit Exchange

Application Process



Note how once item is complete the button changes to blue.


86 plans available
SORT BY
Premium
PLAN TYPE
Health plans
FILTERS
Monthly premium
less than $200 (1)
less than $300 (35)
less than $400 (83)
less than $500 (86)
Plan category
Bronze plans (29)
Silver plans (39)
Gold plans (18)
Plan type
PPO (24)
HMO (49)
POS (13)
Medical management programs
Asthma (84)
Heart Disease (86)
Depression (58)
Diabetes (86)
High Blood Pressure and High Cholesterol (61)
Low Back Pain (45)
Ambetter from Buckeye Health · Ambetter Essential Care 1 (2016)
Bronze HMO | Plan ID: 41047OH0010017
Estimated monthly premium
$196
Deductible
$6,800
Estimated Individual Total
Out-of-pocket maximum
$6,800
Estimated Individual Total
Estimated total yearly costs
Total premiums for the year $2,347
Deductible, copayments, and other costs $1,490
Total $3,837
EDIT
Understand this
Your doctors, medical facilities, and prescription drugs
EDIT
BETA
Copayments / Coinsurance
Emergency room care: No Charge After Deductible
Generic drugs: $20
Primary doctor: No Charge After Deductible
Specialist doctor: No Charge After Deductible
LEARN MORE ABOUT THIS PLAN
COMPARE
CareSource · CareSource Just4Me Bronze

Apply by Phone

Application Process

1-800-318-2596

The FFM Call Center is open 7 days per week, 24 hours per day
(closed Memorial Day, July 4th, Labor Day, Thanksgiving Day and Christmas)

When a consumer applies by phone, a customer service representative will fill out the application with the information the consumer is giving during the call.

They will then read the eligibility results to the consumer and explain those results.

The customer service rep will then tell the consumers the plans that are available with details about premium payment, deductibles, etc. The CSR is in plan compare and verbally reviewing the information with the consumer.

TTY 1-855-889-4325

Application Process

Verbal Authorization

You can call the FFM Call Center **with** a consumer for assistance in applying or enrolling or assisting with other issues.

Consumers can call the Marketplace Call Center with his/her third party representative and give **verbal authorization** for the third party representative to speak on their behalf.

This authorization can last for up to one year unless the consumer calls back to remove the authorization.

Call center purposes only

Must call with the consumer

Lasts up to one Year

Allows Assisters to facilitate *communication* not act

Application Process

Non English speaking consumers can get assistance through the Health Insurance Marketplace Call Center. They will be connected to an interpretation service to assist through the application and enrollment process.

Application Process

The FFM Call Center can be used for any need

- **Information**
- **Pre-Screening**
- **Applying**
- **Enrolling**
- **Reporting Changes**
- **Reporting problems or issues**
- **Password reset**
- **SEPs**

Apply by Mail

Application Process

Paper Applications

Paper Applications can be filled out and mailed.

Eligibility Results are mailed to applicant within two weeks

Consumers can then either create an online account or call the call center to complete their enrollment.

The paper application for 2017 coverage will be available November 1, 2016.

Paper application can be printed from the HealthCare.gov website.

Application Process

Health Insurance Marketplace

09/2015

Form Approved
OMB No. 0938-1191

Application for Health Coverage & Help Paying Costs

Apply faster online

Apply faster online at HealthCare.gov.

Use this application to see what coverage you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A new tax credit that can immediately help pay your premiums for health coverage.
- Free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP).

You may qualify for a free or low-cost program, even if you earn as much as $95,400 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- **Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.**
- If you're single, you may be able to use a short form. Visit HealthCare.gov.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

What you may need to apply

- Social Security Numbers (or document numbers for any eligible immigrants who need coverage).
- Employer and income information for everyone in your family (for example, from pay stubs, W-2 forms, or wage and tax statements).
- Policy numbers for any current health insurance.
- Information about any job-related health insurance available to your family.

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, visit HealthCare.gov or see instructions.

What happens next?

Send your complete, signed application to the address on page 7. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow up with you within 1–2 weeks, and **you may receive a call from the Marketplace if we need more information.** You'll get an eligibility determination letter in the mail after your application is processed. If you don't hear from us, contact the Marketplace Call Center. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** HealthCare.gov.
- **Phone:** Call the Marketplace Call Center at **1-800-318-2596**. TTY users should call 1-855-889-4325.
- **In person:** There may be counselors in your area who can help. Visit HealthCare.gov, or call the Marketplace Call Center at **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596.**
- **Other languages:** If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average 45 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Delays

Must wait for FFM to enter

Questions may not be answered completely

Will involve follow up

Application Process

Please print in capital letters using black or dark blue ink only.
Fill in the circles (○) like this → ●.

STEP 1: Tell us about yourself

(We need one adult in the family to be the contact person for your application.)

1. First name	Middle name	Last name	Suffix

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number

4. City	5. State	6. ZIP code	7. County, parish, or township

8. Mailing address (if different from home address)	9. Apartment or suite number

10. City	11. State	12. ZIP code	13. County, parish, or township

14. Daytime phone number	15. Evening phone number
( ) –	( ) –

16. Do you want to get information about this application by email? ..... ○ Yes ○ No

Email address:

17. What's your preferred spoken language? What's your preferred written language?

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Application Process

STEP 2: Tell us about your family.

Who do you need to include on this application?
Complete the Step 2 pages for every person in your family and household, even if the person has health coverage already. The information in this application helps us make sure everyone gets the best coverage they can. The amount of help or type of program you qualify for is based on the number of people in your family and their incomes. If you don't include someone, even if they already have health coverage, your eligibility results could be affected.

For adults who need coverage:
Include these people even if they aren't applying for health coverage themselves:

- Any spouse
- Any son or daughter under age 21 they live with, including stepchildren
- Any other person on the same federal income tax return (including any children over age 21 who are claimed on a parent's tax return). You don't need to file taxes to get health coverage.

For children under age 21 who need coverage:
Include these people even if they aren't applying for health coverage themselves:

- Any parent (or stepparent) they live with
- Any sibling they live with
- Any son or daughter they live with, including stepchildren
- Any other person on the same federal income tax return. You don't need to file taxes to get health coverage.

Complete Step 2 for each person in your family.
Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them.

You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure, as required by law. We'll use personal information only to check if you're eligible for health coverage.

Application Process

STEP 2: PERSON 1 (Start with yourself.)

Complete Step 2 for yourself, your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name	Middle name	Last name	Suffix

2. Relationship to PERSON 1?	3. Are you married?	4. Date of birth (mm/dd/yyyy)	5. Sex
SELF	◯ Yes ◯ No	___ / ___ / ____	◯ Male ◯ Female

6. **Social Security Number (SSN)** ___ – ___ – ____

We need a Social Security number (SSN) if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who's eligible for help paying for health coverage. If you need help getting an SSN, visit **socialsecurity.gov**, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

7. **Do you plan to file a federal income tax return NEXT YEAR?** *You can still apply for coverage even if you don't file a federal income tax return.*

◯ **YES. If yes,** please answer questions a–c. ◯ **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? ..... ◯ Yes ◯ No

If yes, write name of spouse:

b. Will you claim any dependents on your tax return? ..... ◯ Yes ◯ No

If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? ..... ◯ Yes ◯ No

If yes, please list the name of the tax filer: How are you related to the tax filer?

8. Are you pregnant? ..... ◯ Yes ◯ No a. **If yes,** how many babies are expected during this pregnancy? ☐

9. **Do you need health coverage?** *Even if you have coverage, there might be a program with better coverage or lower costs.*

◯ **YES. If yes,** answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ..... ◯ Yes ◯ No

Application Process

11. Are you a **U.S. citizen** or **U.S. national**? ◯ Yes ◯ No

12. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)*

◯ **YES. If yes,** complete a and b. ◯ **NO. If no,** continue to question 13.

a. Alien number:

b. Certificate number:

After you complete a and b, SKIP to question 14.

13. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? ◯ **YES.** Enter document type and ID number. *See instructions.*

Immigration document type	Status type (optional)	Write your name as it appears on your immigration document.

Alien or I-94 number

Card number or passport number

SEVIS ID or expiration date (optional)

Other (category code or country of issuance)

a. Have you lived in the U.S. since 1996? ◯ Yes ◯ No

b. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ◯ Yes ◯ No

14. Do you want help paying for medical bills from the last 3 months? ◯ Yes ◯ No

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? *(Select "yes" if you or your spouse takes care of this child.)* ◯ Yes ◯ No

16. Tell us the names and relationships of any children under 19 that live with you in your household:

17. Are you a full-time student? ◯ Yes ◯ No

18. Were you in foster care at age 18 or older? ◯ Yes ◯ No

Optional: *(Fill in all that apply.)*

19. If Hispanic/Latino, ethnicity: ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban ◯ Other _____

20. Race: ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other _____

Application Process

STEP 2: PERSON 1 (Continue with yourself.)

Current job & income information

○ **Employed:** If you're currently employed, tell us about your income. Start with question 21.

○ **Not employed:** Skip to question 31.

○ **Self-employed:** Skip to question 30.

Current job 1:

21. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 22. Employer phone number ( ) –

23. Wages/tips (before taxes) $ ○ Hourly ○ Twice a month ○ Weekly ○ Monthly ○ Every 2 weeks ○ Yearly

24. Average hours worked each WEEK

Current job 2: (If you have additional jobs and need more space, attach another sheet of paper.)

25. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 26. Employer phone number ( ) –

27. Wages/tips (before taxes) $ ○ Hourly ○ Twice a month ○ Weekly ○ Monthly ○ Every 2 weeks ○ Yearly

28. Average hours worked each WEEK

29. **In the past year, did you:** ○ Change jobs ○ Stop working ○ Start working fewer hours None of these

30. **If self-employed, answer a and b:**

Application Process

31. **Other income you get this month:** Fill in all that apply, and give the amount and how often you get it. Fill in here if none. ◯
NOTE: You **don't** need to tell us about income from child support, veteran's payments, or Supplemental Security Income (SSI).

◯ Unemployment	$	How often?	◯ Alimony received	$	How often?
◯ Pension	$	How often?	◯ Net farming/fishing	$	How often?
◯ Social Security	$	How often?	◯ Net rental/royalty	$	How often?
◯ Retirement accounts	$	How often?	◯ Other income Type:	$	How often?

32. **Deductions:** Fill in all that apply, and give the amount and how often you pay it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include child support that you pay, or a cost already considered in your answer to net self-employment (question 30b).

◯ Alimony paid	$	How often?	◯ Other deductions Type:	$	How often?
◯ Student loan interest	$	How often?			

33. **Complete this question if your income changes during the year**, like if you only work at a job for part of the year or receive a benefit for certain months. If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year**	Your total income **next** year (if you think it will be different)
$	$

Thanks! This is all we need to know about you.

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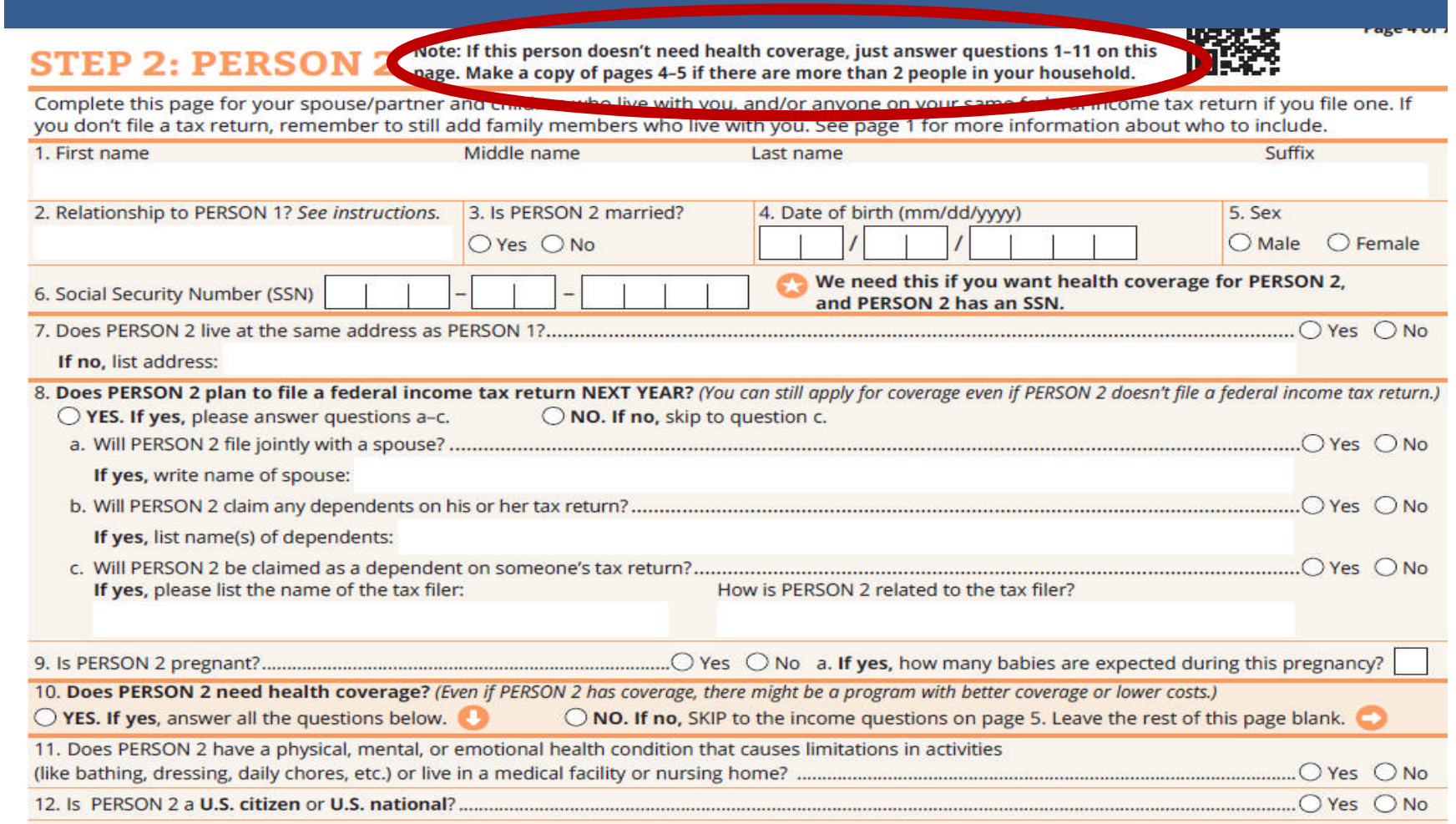
Application Process



STEP 2: PERSON 2

Note: If this person doesn't need health coverage, just answer questions 1–11 on this page. Make a copy of pages 4–5 if there are more than 2 people in your household.

Page 4 of 7

Complete this page for your spouse/partner and [illegible] who live with you, and/or anyone on your same federal income tax return if you file one. If you don't file a tax return, remember to still add family members who live with you. See page 1 for more information about who to include.

1. First name | Middle name | Last name | Suffix

2. Relationship to PERSON 1? *See instructions.*

3. Is PERSON 2 married? ◯ Yes ◯ No

4. Date of birth (mm/dd/yyyy) ___ / ___ / ___

5. Sex ◯ Male ◯ Female

6. Social Security Number (SSN) ___ – ___ – ___ **We need this if you want health coverage for PERSON 2, and PERSON 2 has an SSN.**

7. Does PERSON 2 live at the same address as PERSON 1? ◯ Yes ◯ No
   If no, list address:

8. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?** *(You can still apply for coverage even if PERSON 2 doesn't file a federal income tax return.)*
   ◯ **YES. If yes,** please answer questions a–c. ◯ **NO. If no,** skip to question c.
   a. Will PERSON 2 file jointly with a spouse? ◯ Yes ◯ No
      If yes, write name of spouse:
   b. Will PERSON 2 claim any dependents on his or her tax return? ◯ Yes ◯ No
      If yes, list name(s) of dependents:
   c. Will PERSON 2 be claimed as a dependent on someone's tax return? ◯ Yes ◯ No
      If yes, please list the name of the tax filer: How is PERSON 2 related to the tax filer?

9. Is PERSON 2 pregnant? ◯ Yes ◯ No a. **If yes,** how many babies are expected during this pregnancy? ☐

10. **Does PERSON 2 need health coverage?** *(Even if PERSON 2 has coverage, there might be a program with better coverage or lower costs.)*
    ◯ **YES. If yes**, answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

11. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ◯ Yes ◯ No

12. Is PERSON 2 a **U.S. citizen** or **U.S. national**? ◯ Yes ◯ No

Application Process

SKIP to question 15.

14. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status? ◯ **YES.** Enter document type and ID number. *See instructions.*

Immigration document type:	Status type (optional):	Write PERSON 2's name as it appears on their immigration document.

Alien or I-94 number	Card number or passport number
SEVIS ID or expiration date (optional)	Other (category code or country of issuance)

a. Has PERSON 2 lived in the U.S. since 1996? ◯ Yes ◯ No

b. Is PERSON 2, or PERSON 2's spouse or parent, a veteran or an active-duty member of the U.S. military? ◯ Yes ◯ No

15. Does PERSON 2 want help paying for medical bills from the last 3 months? ◯ Yes ◯ No

16. Does PERSON 2 live with at least one child under the age of 19, and is PERSON 2 the main person taking care of this child?
(Select "yes" if PERSON 2 or their spouse takes care of this child.) ◯ Yes ◯ No

17. Tell us the names and relationships of any children under 19 that live with PERSON 2 in their household: *(These can be the same children listed on page 2.)*

18. Was PERSON 2 in foster care at age 18 or older? ◯ Yes ◯ No

Please answer these questions if PERSON 2 is 22 or younger:

19. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ◯ Yes ◯ No

a. **If yes**, end date: ___ / ___ / ____ b. Reason the insurance ended:

20. Is PERSON 2 a full-time student? ◯ Yes ◯ No

Optional: *(Fill in all that apply.)*

21. If Hispanic/Latino, ethnicity: ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban ◯ Other _____

22. Race: ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other _____

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov, or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

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STEP 3: American Indian or Alaska Native (AI/AN) family member(s)

1. **Are you or is anyone in your family American Indian or Alaska Native?**

◯ **NO. If no,** continue to Step 4. ◯ **YES. If yes,** continue to Step 4, plus complete Appendix B and include with application.

STEP 4: Your family's health coverage

1. **For every year that you got a premium tax credit, did your household file a tax return and reconcile any premium tax credit you used?**

◯ **YES, premium tax credits were reconciled. Fill in the circle only if ALL of these apply to you:**

- You used advance payments of premium tax credits (APTC) in one or more past years to help lower your costs for Marketplace coverage.
- The tax filer for your household filed a federal income tax return for each of these years.
- The tax return filed compared the amount of APTC used to the rest of the tax return information for each year.

2. **Was anyone on this application found not eligible for Medicaid or the Children's Health Insurance Program (CHIP) in the past 90 days?** *(Select yes only if someone was found not eligible for this coverage by your state, not by the Marketplace.)* ◯ Yes ◯ No

Who?

Or, was anyone on this application found not eligible for Medicaid or CHIP due to their immigration status since October 1, 2013? ◯ Yes ◯ No

Who?

3. **Did anyone on this application apply for coverage during the Marketplace open enrollment period?** ◯ Yes ◯ No

Who?

4. **Is anyone listed on this application offered health coverage from a job?** *Check yes even if the coverage is from someone else's job, like a parent or spouse, even if they don't accept the coverage.*

◯ **YES.** Continue and then complete Appendix A. Is this a state employee benefit plan? ◯ Yes ◯ No

◯ **NO.**

5. **Is anyone enrolled in health coverage now?**

◯ **YES. If yes,** continue to question 6. ◯ **NO. If no,** SKIP to Step 5.

6. **Information about current health coverage.** *(Make a copy of this page if more than 2 people have health coverage now.)*
Write the type of coverage, like employer insurance, COBRA, Medicaid, CHIP, Medicare, TRICARE, VA health care program, Peace Corps, or other.
(Don't tell us about TRICARE if you have Direct Care or Line of Duty.)

Name of person enrolled in health coverage

Type of coverage:

Application Process

6. **Information about current health coverage.** *(Make a copy of this page if more than 2 people have health coverage now.)*
Write the type of coverage, like employer insurance, COBRA, Medicaid, CHIP, Medicare, TRICARE, VA health care program, Peace Corps, or other.
(Don't tell us about TRICARE if you have Direct Care or Line of Duty.)

PERSON 1:

Name of person enrolled in health coverage

Type of coverage:
◯ Employer insurance ◯ COBRA ◯ Medicaid ◯ CHIP ◯ Medicare ◯ TRICARE ◯ VA health care program ◯ Peace Corps ◯ Other

If it's employer insurance: *(You'll also need to complete Appendix A.)*
Name of health insurance company | Policy/ID number

If it's another kind of coverage:
Name of health insurance company | Policy/ID number

Is this a limited-benefit plan, like a school accident policy? ◯ Yes ◯ No

PERSON 2:

Name of person enrolled in health coverage

Type of coverage:
◯ Employer insurance ◯ COBRA ◯ Medicaid ◯ CHIP ◯ Medicare ◯ TRICARE ◯ VA health care program ◯ Peace Corps ◯ Other

If it's employer insurance: *(You'll also need to complete Appendix A.)*
Name of health insurance company | Policy/ID number

If it's another kind of coverage:
Name of health insurance company | Policy/ID number

Is this a limited-benefit plan, like a school accident policy? ◯ Yes ◯ No

Application Process

STEP 5: Your agreement & signature

1. **Do you agree to allow the Marketplace to use income data, including information from tax returns, for the next 5 years?** ..... ◯ Yes ◯ No

To make it easier to determine your eligibility for help paying for coverage in future years, you can agree to allow the Marketplace to use updated income data, including information from tax returns. The Marketplace will send a notice and let you make any changes. The Marketplace will check to make sure you're still eligible, and may have to ask you to prove that your income still qualifies. You can opt out at any time.

If no, automatically update my information for the next:

◯ 4 years ◯ 2 years ◯ Don't use my tax data to renew my eligibility for help paying for health coverage (selecting this option may impact your ability to get help paying for coverage at renewal.)
◯ 3 years ◯ 1 year

2. **Is anyone applying for health insurance on this application incarcerated (detained or jailed)?** ..... ◯ Yes ◯ No

If yes, tell us the person's name. The name of the incarcerated person is:

◯ Fill in here if this person is facing disposition of charges.

If anyone on this application is eligible for Medicaid:

- I'm giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ..... ◯ Yes ◯ No
- If yes, I know I'll be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that I must tell the Health Insurance Marketplace within 30 days if anything changes (and is different than) what I wrote on this application. I can visit HealthCare.gov or call **1-800-318-2596** to report any changes. I understand that a change in my information could affect my eligibility as well as eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I know that information on this form will be used only to determine eligibility for health coverage, help paying for coverage (if requested), and for lawful purposes of the Marketplace and programs that help pay for coverage.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Application Process

What should I do if I think my eligibility results are wrong?

If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Please review your eligibility notice to find appeals instructions specific to each person in your household who applies for coverage, including how many days you have to request an appeal. Here's important information to consider when requesting an appeal:

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal your Marketplace eligibility results, visit HealthCare.gov/marketplace-appeals/. Or call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**. You can also mail an appeal request form or your own letter requesting an appeal to **Health Insurance Marketplace**, Dept. of Health and Human Services, 465 Industrial Blvd., London, KY 40750-0001. You can appeal eligibility for purchasing health coverage through the Marketplace, enrollment periods, tax credits, cost-sharing reductions, Medicaid, and CHIP, if you were denied these. If you qualify for tax credits or cost-sharing reductions, you can appeal the amount we determined you're eligible for. Depending on your state, you may be able to appeal through the Marketplace or you may have to request an appeal with the state Medicaid or CHIP agency.

PERSON 1 should sign this application. If you're an authorized representative, you may sign here as long as PERSON 1 signed Appendix C.

Signature	Date signed (mm/dd/yyyy)
	/ /

If you're signing this application outside of Open Enrollment (between November 1 and January 30), make sure you review Appendix D ("Questions about life changes").

STEP 6: Mail completed application

Mail your signed application to:
Health Insurance Marketplace
Dept. of Health and Human Services
465 Industrial Blvd.
London, KY 40750-0001

If you want to register to vote, you can complete a voter registration form at www.eac.gov.

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov, or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

Application Process

Appendix A

Form Approved
OMB No. 0938-1191

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job, even if they don't accept the coverage. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.
Make a copy of this page and take it to the employer who offers coverage to help you answer these questions.

EMPLOYEE INFORMATION

1. Employee name (First, Middle, Last)	2. Employee Social Security Number
	___ – ___ – ____

EMPLOYER INFORMATION

3. Employer name	4. Employer Identification Number (EIN)
	__ – _____
5. Employer address	6. Employer phone number
	(___) ___ – ____
7. City	8. State / 9. ZIP code
	__ / _____

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above)	12. Email address
(___) ___ – ____	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?

◯ **YES (Continue)** ◯ **NO (Stop here, and return to Step 5 in the application.)**

a. **If you're in a waiting or probationary period, when can you enroll in coverage?** (mm/dd/yyyy)

__ / __ / ____

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Application Process

13. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?

◯ **YES (Continue)** ◯ **NO (Stop here, and return to Step 5 in the application.)**

a. **If you're in a waiting or probationary period, when can you enroll in coverage?** (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

List the names of anyone else who is eligible for coverage from this job.

Name	Name	Name

Tell us about the lowest-cost health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ..... ◯ Yes ◯ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$**

b. How often? ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Once a month ◯ Quarterly ◯ Yearly (Go to next question.)

16. What change, if any, will the employer make for the new plan year?

◯ Employer won't offer health coverage.

◯ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan that meets the minimum value standard* and is available to the employee only. (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? **$**

b. How often? ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Once a month ◯ Quarterly ◯ Yearly

c. Date of change: (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

* A health plan meets the minimum value standard if pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. In other words, in most cases a plan that meets minimum value will cover 60% of covered medical costs. You'd pay 40%. Most job-based plans meet the minimum value standard.

Application Process

Appendix B

Form Approved
OMB No. 0938-1191

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native and are applying for coverage. Submit this with your "Application for Health Coverage & Help Paying Costs."

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the questions below to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

AI/AN PERSON 1:

1. Name (First name, Middle name, Last name)

2. Member of a federally recognized tribe? ◯ Yes ◯ No

If yes, Tribe name: | State tribe is located in:

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ◯ Yes ◯ No

If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ◯ Yes ◯ No

4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

$ | How often?

Application Process

Appendix C

Form Approved
OMB No. 0938-1191

Assistance with completing this application

For certified application counselors, navigators, agents, and brokers only
Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)
   ☐☐ / ☐☐ / ☐☐☐☐
2. First name, Middle name, Last name, & Suffix
3. Organization name
4. ID number (if applicable)
5. Agents/Brokers only: NPN number

You can choose an authorized representative.
You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change or remove your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)
2. Address
3. Apartment or suite number
4. City
5. State ☐☐
6. ZIP code ☐☐☐☐☐
7. Phone number

Application Process

Appendix D

Form Approved
OMB No. 0938-1191

Questions about life changes

(You must complete the rest of this application along with this page. Don't submit this page by itself.)

If anyone on this application experienced certain life changes in the past 60 days, fill out the following questions. Certain life changes allow your coverage through the Marketplace to start right away. We also recommend you answer these questions if you're applying after the annual Open Enrollment Period ends and before the next annual Open Enrollment Period starts.

These questions are optional. If your life circumstances haven't changed, you can leave the answers blank. You can enroll in Medicaid and the Children's Health Insurance Program (CHIP) any time of the year, even if you didn't experience life changes. Members of federally recognized tribes and Alaska Native shareholders can enroll in coverage through the Marketplace any time of the year.

Tell us about changes in your household.

1. Someone lost health coverage in the last 60 days, or expects to lose coverage in the next 60 days.

Names	Date coverage ended or will end (mm/dd/yyyy)
☐ Check here if coverage ended because not paying premiums.	/ /

2. Someone got married in the last 60 days.

Names	Date (mm/dd/yyyy)
	/ /

3. Someone was released from incarceration, detention, or jail in the last 60 days.

Names	Date (mm/dd/yyyy)
	/ /

4. Someone gained eligible immigration status in the last 60 days.

Names	Date (mm/dd/yyyy)
	/ /

Application Process

Federal Call center will enter the paper application upon receipt.

Eligibility Results are mailed to the consumer within 2 weeks

If the application is not complete, the FFM will call the consumer to gather missing information.

Eligibility results will have an application number. Consumer should keep this for their records.

Once the consumer has received their Eligibility Determination, they can either create an online account or call the call center to continue with enrollment.

Application Process

Online

Quick

Dynamic application that gathers all necessary information

Complete process at one time

Must create an online account

Must pass ID Proofing before moving forward

Paper

Can complete several in a single event

Can send copies of ID information with application

Delays

Must wait for FFM to enter

Questions may not be answered completely

Will involve follow up

Call Center

Quick

All info is entered

Complete process at one time

Cannot see the screen when they are reviewing available plans

Wait times during OEP

Thank you